

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09723

09750

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 600 National Highway-La Vale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
3. NAME OF DECEASED (Type or print) Lula		d. STREET ADDRESS 600 National Highway-La Vale	
4. DATE OF DEATH 9		Month 2	Day 1959
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 8, 1898	
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Franklin W. Hammersmith		14. MOTHER'S MAIDEN NAME Mary Frances Robinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Jack D. Boden, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ceremia			
DUE TO 171X			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Urinary obstruction			
DUE TO (c) Carcinoma of cervix with metastases 2 1/2 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 1957, to Sept 2, 1959 , that I last saw the deceased alive on Sept 1, 1959 , and that death occurred at 4 P. M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) Cumberland at Washington St.			
DATE SIGNED Thomas F. Lewis			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) Thomas F. Lewis, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-5-59	
22c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		24a. REC'D BY REGISTRAR DATE SEP 8 '59	
		24b. REGISTRAR'S SIGNATURE Orlins & Krause	

TO HOSPITAL OR / ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. ATSM(E)5
SM 9/55

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
09724
0975 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE W. Va.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgeley,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hosp. D.O.A.		d. STREET ADDRESS 4 Carpenter Ave.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Retta	Middle May	Last Brant
4. DATE OF DEATH	Month Sept.	Day 24,	Year 19 59
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 24, 1871
		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 88 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife,		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Sharpsburg, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jonathan Moats		14. MOTHER'S MAIDEN NAME Margaret Stobbs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No, If yes, give war or dates of service		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Arthur E. Brant		Address Ridgeley, W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		INTERVAL BETWEEN ONSET AND DEATH sudden	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		coronary occlusion	
DUE TO (c)		coronary sclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Sept. 24, 1959
EXAMINER'S NAME (Type) Dr. Benedict Skitarelic	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/26/59	22c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Burial Park	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George	ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR SEP 28 1959	24b. REGISTRAR'S SIGNATURE <i>Arthur E. Brant</i>

MISSOURI STATE BOARD OF EXAMINERS OF CERTIFICATE OF DEATH

MISSOURI



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the Health Department. OR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

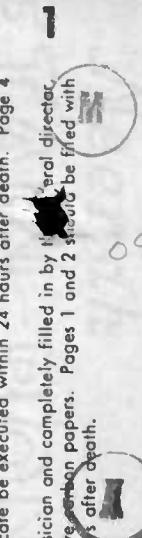
09725

Reg. Dist. No.

09803

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport—Rural		c. LENGTH OF STAY IN lb 23 lbs 2 Ds.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1 mile East of Westernport		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First McComas	Middle Broadwater	4. DATE OF DEATH Sept. 17 Doy 1959 Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> Jan. 13, 1893	9. AGE (in years last birthday) 66 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Kennerd Broadwater		14. MOTHER'S MAIDEN NAME Annie Wiland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Joseph Grandstaff—Suitland, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 974X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Address INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hanged self by neck by rope	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City, town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type)	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED Sept 14 1959		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/21/59	22c. NAME OF CEMETERY OR CREMATORIUM Laurel Hill	22d. LOCATION (City, town, or county) Moscow (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE E. J. Brul	ADDRESS Westernport, Md.	24a. REC'D BY REGISTRAR DATE SEP 22 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Knue

STATE ROLL
TAX ROLL



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09752

CERTIFICATE OF DEATH

09726

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. Va.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b Mins.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION D.O.A. Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Violet Pearl Browning		First Violet	Middle Pearl
4. DATE OF DEATH Sept. 24 1959		Last Browning	Month Sept.
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 27, 1918
9. AGE (In years last birthday) 41		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James T. Shrout	
14. MOTHER'S MAIDEN NAME Mary F. Stonebraker		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. 214-07-6410		17. INFORMANT Mr. Irvin Browning, Wiley Ford, W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure		INTERVAL BETWEEN ONSET AND DEATH 2 hours.	
DUE TO 410X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Mitral stenosis			
DUE TO (c) Rheumatic fever			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 22, 1959 , to Sept. 24, 1959 , that I last saw the deceased alive on Sept. 24, 1959 , and that death occurred at 11:05P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 133 Virginia Avenue		DATE SIGNED 9-25-59	
ACTUAL SIGNATURE <i>G. Overton Himmelwright</i>		M.D. PHYSICIAN'S NAME (Type) G. Overton Himmelwright, M.D., Cumberland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-27-1959	
22c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		24a. REC'D BY REGISTRAR DATE SEP 29 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Clifford & Thomas	

THE STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to a burial, cremation, or removal, and in any event within 72 hours after death.

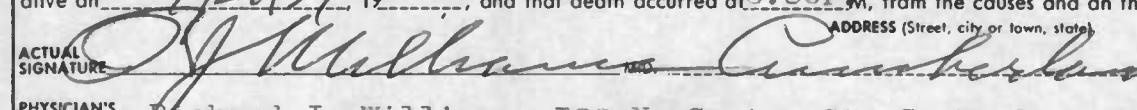
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09727

09753

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 58yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 216 Arch Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 216 Arch Street				d. STREET ADDRESS 216 Arch Street		e. IS RESIDENCE ON A FARMS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Jasper		First	Middle Carl	Lost	4. DATE OF DEATH Sept 29, 1959	Month	Day	Year
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 18, 1885		9. AGE (In years lost birthday) 73 yrs.	IF UNDER 1 YEAR Months 2		IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Bottle Washer		10b. KIND OF BUSINESS OR INDUSTRY Milk Plant		11. BIRTHPLACE (State or foreign country) Towncreek, Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Denton B. Bucy				14. MOTHER'S MAIDEN NAME Mary Huff				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-05-8033 A		17. INFORMANT Nellie Mae Redhead		Address same as above		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Car Pulmonary DUE TO 2 yrs 501X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Chronic Asthma DUE TO 5 yrs (c) Bronchitis								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cumberland		(County) Calvert (State) Md.
21. I certify that I attended the deceased from 2/24/59 , 19, to 9/29/59 , 19, that I last saw the deceased alive on 9/28/59 , 19, and that death occurred at 8:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland DATE SIGNED 9/30/59								
ACTUAL SIGNATURE 		PHYSICIAN'S NAME (Type) Richard J. Williams ADDRESS 122 N. Centre St. Cumberland, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-2-59		22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		22d. LOCATION (City, town, or county) Cumberland, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR OCT 51 '59		24b. REGISTRAR'S SIGNATURE Orville S. Krause		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09728

09754

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
 may be retained by the hospital or attending physician and completely filled in by the funeral director.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 3 DAYS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First EMMA	Middle 	Last CAMERON	
4. DATE OF DEATH	Month SEPTEMBER	Day 3	Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 18, 1886	
9. AGE (In years last birthday) 72 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work	11. KIND OF BUSINESS OR INDUSTRY Own Home	12. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME ROBERT MOFFATT	14. MOTHER'S MAIDEN NAME MARTHA STARBRIGHT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT MEMORIAL HOSPITAL,	Address CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH Unknown				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 8.31.1959	(County) 9. 3. 1959	(State) MD		
21. I certify that I attended the deceased from 8.31.1959 to 9. 3. 1959 that I last saw the deceased alive on 9. 2. 1959 , and that death occurred at 7:43 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE W.F. WILLIAMS DATE SIGNED 9. 3. 1959				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/6/1959	22c. NAME OF CEMETERY OR CREMATORIAL Oak Hill Cemetery	22d. LOCATION (City, town, or county) Lonaconing, MD.
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHORN		ADDRESS LONACONING, MD.	24a. REC'D BY REGISTRAR DATE SEP 8 '59	24b. REGISTRAR'S SIGNATURE Arthur & Thru

09729

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ALLEGANY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 11 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA VALE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL			d. STREET ADDRESS 329 NATIONAL HIGHWAY		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First B.	Middle HARRISON	Last CARL	4. DATE OF DEATH	Month SEPTEMBER Day 25 Year 19 59
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 11-22-1889	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY Railroad clerk		11. BIRTHPLACE (State or foreign country) HANCOCK, MARYLAND	
13. FATHER'S NAME DANIEL CARL			14. MOTHER'S MAIDEN NAME ANNIE SPRENKLE		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 705-10-4581		INFORMANT WARWICK & MEMORIAL AVENUE MEMORIAL HOSPITAL - CUMBERLAND MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 610X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH <i>Benign hyper trophy prostate?</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerosis, coronary sclerosis					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> or work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 9-14-59	(County) (State)
21. I certify that I attended the deceased from 9-24-59 to 9-25-59 that I last saw the deceased alive on 9-24-59 and that death occurred on 9-25-59 at 4:30 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Howard L. Tolson					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/27/59		22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox			22d. LOCATION (City, town, or county) (State) Cumberland Maryland		
ADDRESS Cumberland Maryland			24a. REC'D BY REGISTRAR DATE SEP 29 '59		
			24b. REGISTRAR'S SIGNATURE Arthur H. Tolson		

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4
1SM 9/5B

5. ~~1000~~ ~~1000~~ ~~1000~~ ~~1000~~

6. ~~1000~~ ~~1000~~ ~~1000~~ ~~1000~~

7. ~~1000~~ ~~1000~~ ~~1000~~ ~~1000~~

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
 1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09756

CERTIFICATE OF DEATH

Reg. Dist. No.

09730

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		d. STREET ADDRESS 1 202 Columbia St. City.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. DATE OF DEATH September 7, 1959	
3. NAME OF DECEASED (Type or print) Norman	First E	Middle C	Last Chirdon
4. DATE OF DEATH September 7, 1959	Month September	Day 7	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/12, -1915
9. AGE (In years last birthday) 44	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Selmon	11. BIRTHPLACE (State or foreign country) Pa.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Charles Chirdon	14. MOTHER'S MAIDEN NAME Gertrude Conrad		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 1	INFORMANT Wife Jane	Address 202 Columbia St.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1			
DUE TO Myocardial Infarction			
INTERVAL BETWEEN ONSET AND DEATH 1 hour			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Coronary Artery Disease			
INTERVAL BETWEEN ONSET AND DEATH 2-3 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January , 19 58 , to September , 19 59 , that I last saw the deceased alive on Sept. 7 , 19 59 , and that death occurred at 4:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE William P. James		M.D. 441 N. Centre St 9-9-59	
PHYSICIAN'S NAME (Type) Dr. William P. James		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/10/59	
22c. NAME OF CEMETERY OR CREMATORIUM SS. Peter & Paul		22d. LOCATION (City, town, or county) Cumberland	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Steinke		ADDRESS Cumb. Md.	
24a. REC'D BY REGISTRAR DATE SEP 11 '59		24b. REGISTRAR'S SIGNATURE Arthur & Thorne	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
09731 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09731

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE WEST VIRGINIA		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 8 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PAW PAW		d. STREET ADDRESS 85 x 3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF -DECEASED (Type or print)	First Patricia	Middle	Last Clark	4. DATE OF DEATH	Month Sept.	Day 30	Year 1959
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH MARCH 21, 1939	9. AGE (In years last birthday) 20 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME HOMER PARKER		14. MOTHER'S MAIDEN NAME MARY BOWERS					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT PATIENTS CHART		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism, Massive							
465 X DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED Sept. 30, 1959
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF OCT. 3, 1959	22c. NAME OF CEMETERY OR CREMATORIAL Woodrow Cem.	22d. LOCATION (City, town, or county) PAW PAW		(State) W. Va.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. L. Bailey</i>	ADDRESS Parks Funeral Home, Port City, Virginia	24a. REC'D BY REGISTRAR DATE OCT 5 1959		24b. REGISTRAR'S SIGNATURE Arthur & Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09758

CERTIFICATE OF DEATH

Reg. Dist. No.

09732

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 11 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Theresa		First Elizabeth	Middle Cline
4. DATE OF DEATH Sept. 22 1959	Month Sept.	Day 22	Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/1/98
9. AGE (In years lost birthday) 61 yrs.	10. IF UNDER 1 YEAR Months 61	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Cumberland, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Lloyd Ryland (Dec)		14. MOTHER'S MAIDEN NAME Margaret Brodigan (Dec)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	INFORMANT Mrs. Kenneth Imler Altoona, Penna.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Pulmonary atelectasis bilateral		INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
(b) Myocardial ischemia		—	
(c) Coronary artery insufficiency		—	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obstruction due to chronic cholelithiasis & pericholelithiasis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Sept 20, 1959	
19. WAS AUTOPSY PERFORMED? NO	20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hotel Algonquin Cumberland Maryland		20f. (City or town) Cumberland
(County) Maryland	(State) Md.	21. I certify that I attended the deceased from Sept 17, 1959 to Sept 21, 1959 that I last saw the deceased alive on Sept 20, 1959 and that death occurred at 8 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Thomas F. Lewis PHYSICIAN'S NAME (Type) Dr. H. P. Lewis M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/25/59	22c. NAME OF CEMETERY OR CREMATORIUM St. Patrick's Cem.
22d. LOCATION (City, town, or county) Cumberland, Md.		24a. REC'D BY REGISTRAR DATE SEP 28 '59	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Md.	24b. REGISTRAR'S SIGNATURE Arthur S. Lewis

CELESTE ST. GEORGE

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09733

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland,		d. STREET ADDRESS 119 So. Allegany St.,		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 119 So. Allegany St.,				d. STREET ADDRESS 119 So. Allegany St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First CHARLES	Middle LEO	Last COLLINS	4. DATE OF DEATH Sept. 19, 1959	Month Sept.	Day 19	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 13, 1904	9. AGE (In years (last birthday) 55 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-employed barber		10b. KIND OF BUSINESS OR INDUSTRY Barbering		11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. 060-10-4901		17. INFORMANT Mr. James Alfred Avirett		Address Cumb. Md. 1, Washington St.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary ; Occlusion</u> INTERVAL BETWEEN ONSET AND DEATH sudden								
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary sclerosis</u> -----								
DUE TO (c) -----								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>								
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		<u>Benedict Skitarelic</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED Sept. 20, 1959						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/22/59	22c. NAME OF CEMETERY OR CREMATORIUM Sunset Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR DATE SEP 23 '59		24b. REGISTRAR'S SIGNATURE Orilia S. Trahan			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

09734

Reg. Dist. No.

CERTIFICATE OF DEATH

09760

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b ONE DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL & MEMORIAL HOSPITAL WARWICK AVES.				d. STREET ADDRESS 1418 RIVER AVE.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) BESSIE XXXXX		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH APRIL 3 1889	9. AGE (In years lost birthday) 70 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. DAYS	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GROCERY STORE OWNER			10b. KIND OF BUSINESS OR INDUSTRY GROCERY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JAMES INSKEEP				14. MOTHER'S MAIDEN NAME ELIZABETH TRAVIS				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT		Address		
No				MEMORIAL HOSPITAL		CUMBERLAND, MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Myocarditis</i> INTERVAL BETWEEN ONSET AND DEATH 422.1 DUE TO <i>4 yrs</i>								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b) <i>Arteriosclerosis</i>		(c) <i>—</i>		—		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes Mellitus</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>						
20c. TIME OF INJURY Hour a.m. <i>—</i> p.m. <i>—</i>	Month, Day, Year 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>—</i>	(County)	(State)
21. I certify that I attended the deceased from <i>7/4/59</i> , 19, to <i>9/11/59</i> , 19, that I last saw the deceased alive on <i>8/15/59</i> , 19, and that death occurred at <i>7:05PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>ADDRESS</i> (Street, city or town, state) <i>—</i> DATE SIGNED <i>Richard J. Williams, M.D.</i> <i>8/15/59</i>								
ACTUAL SIGNATURE <i>Richard J. Williams, M.D.</i>		PHYSICIAN'S NAME (Type) DR. RICHARD J. WILLIAMS						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9-14-59</i>	22c. NAME OF CEMETERY OR CREMATORIAL Wesley Chapel Cem			22d. LOCATION (City, town, or county) Points, W. Va.			(State)
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli Cumberland, Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE <i>SEP 17 '59</i>	24b. REGISTRAR'S SIGNATURE <i>John S. Kraus</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09804 CERTIFICATE OF DEATH

Reg. Dist. No. 09735

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Railroad Street		d. STREET ADDRESS Railroad Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CHESTER		First	Middle	Lost	4. DATE OF DEATH DAVIS	Month 9/21.1959	Day Year 19
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 2/25/ 1895	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Celanese Employee		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Midland, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elijah Davis				14. MOTHER'S MAIDEN NAME Hannah Boor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Hannah Davis, Midland, MD. (Mother)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Hypertensive Cardiovascular Disease Years Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Coronary Dis. 1 day (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Sept 21, 1959	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 21, 1959 to Sept 21, 1959 , that I last saw the deceased alive on Sept 21, 1959 , and that death occurred at 9:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE John B. Davis, M.D.							
PHYSICIAN'S NAME (Type) John B. Davis, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/23/1959		22c. NAME OF CEMETERY OR CREMATORIUM Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN				ADDRESS LONACONING, MD.		24a. REC'D BY REGISTRAR DATE SEP 25 1959	24b. REGISTRAR'S SIGNATURE John & Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09761 CERTIFICATE OF DEATH

Reg. Dist. No. 09736

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b RURAL and give nearest town) Cresaptown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Martha	Middle E	Last Dawson	
4. DATE OF DEATH	Month 9	Day 17	Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-11-1883	
9. AGE (In years lost birthday) yrs. 76	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. KIND OF BUSINESS OR INDUSTRY Own Home	12. BIRTHPLACE (State or foreign country) Maryland Dawson	
13. FATHER'S NAME Dawson, Theodore	14. MOTHER'S MAIDEN NAME Taylor, Susan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. None	INFORMANT Mrs. Solomon Doss	17. CITIZEN OF WHAT COUNTRY? U.S.A.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerosis heart disease DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day 1	Year 1959	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 43 Greene Street, Cumberland, Md	(County) Cumberland	(State) Md.
21. I certify that I attended the deceased from Sept. 1, 1959 to Sept. 17, 1959 that I last saw the deceased alive on Sept. 14, 1959 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 43 Greene Street, Cumberland, Md
ACTUAL SIGNATURE B. M. Schindler	DATE SIGNED 9-19-59			
PHYSICIAN'S NAME (Type) Dr. B. M. Schindler M.D.	22. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF Sept. 20, 1959 22c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Cemetery 22d. LOCATION (City, town, or county) Cumberland, Maryland (State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland	ADDRESS John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR John J. Hafer	24b. REGISTRAR'S SIGNATURE John J. Hafer

THEATRE HISTORICAL SOCIETY OF AMERICA

HTAS-10-21-017

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

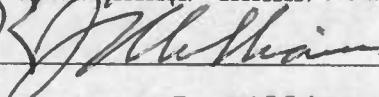
Items 4,21 Film G249 9-28-59 et

09762

CERTIFICATE OF DEATH

Reg. Dist. No.

09737

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 111 Oak St.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
f. STREET ADDRESS 111 Oak St.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Waldron		First James	Middle Waldron
4. DATE OF DEATH Month Sept.	Day 15	Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 11, 1891
9. AGE (In years <small>(less birthday)</small> 67)	10. IF UNDER 1 YEAR Months 6	11. IF UNDER 24 HRS. Days 7	12. Hours 15
13. FATHER'S NAME James H. Day	14. MOTHER'S MAIDEN NAME Jessie Mudge		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes	16. SOCIAL SECURITY NO. 705-09-9883	17. INFORMANT Mrs. James Day, Cumberland, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Colon		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 153.8			
DUE TO (b) Metastasis to Liver -			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19	Month 7	Day 2	Year 1954
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Camp Alley Rd	20f. (City or town) Camp Alley Rd	(County) Allegany
		(State) Md.	
21. I certify that I attended the deceased from 7/2/54 , 19, to 9/10/59 , 19, that I last saw the deceased alive on 3/15/59 , 19, and that death occurred at 10192 Pkwy , from the causes and on the date stated above.			
ACTUAL SIGNATURE 		ADDRESS (Street, city or town, state) 122 S. Centre St.	DATE SIGNED 10/21/59
PHYSICIAN'S NAME (Type) Richard J. Williams, MD.		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-19-1959	22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		ADDRESS	24a. REC'D BY REGISTRAR DATE SEP 21 '59
			24b. REGISTRAR'S SIGNATURE Arthur G. Trahan

ARMED SERVICES STANDBY PROGRAM OF HAZARD-SALTINORE, LA

CERTIFICATE OF DRAFT

ARMED SERVICES STANDBY PROGRAM OF HAZARD-SALTINORE, LA

ARMED SERVICES STANDBY PROGRAM OF HAZARD-SALTINORE, LA

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09738

Reg. Dist. No.

09763

1. PLACE OF DEATH a. COUNTY <i>Allegany</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Allegany</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give road or route) <i>Cumberland</i>		c. LENGTH OF STAY IN 1b <i>69 Da.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Memorial Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Frederick W. Frost</i>		First	Middle
4. DATE OF DEATH <i>Sept. 12, 1959</i>		Lost	Month
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <i>Sept. 13, 1887</i>
9. AGE (In years at birthday) <i>72 yrs.</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Laundry Worker & now Laundry</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Frederick Frost</i>	
14. MOTHER'S MAIDEN NAME <i>Mary Dernowski</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>420-1</i>		17. INFORMANT <i>Mrs. Delphin Bucy, Cumb. Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Artery Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 months</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerosis</i>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Colitis - Fracture of ankle</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <i>It was intopicated & fell down stair</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>7/5/59</i>	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) House 23 Purple Cumb. Valley
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> <i>R. W. Williams</i>		22. ACTUAL SIGNATURE EXAMINER'S NAME (Type)	
22a. CHIEF MEDICAL EXAMINER <i>R. W. Williams</i>		DATE SIGNED <i>9/14/59</i>	
22b. ASSISTANT MEDICAL EXAMINER <i></i>			
22c. DEPUTY MEDICAL EXAMINER <i>R. W. Williams</i>			
22d. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22e. DATE THEREOF <i>9/16/59</i>	
22f. NAME OF CEMETERY OR CREMATORIAL <i>Greenmont Cemetery</i>		22g. LOCATION (City, town, or county) <i>Cumberland, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Louis Stein, Inc., Cumb. Md.</i>		24a. ADDRESS <i></i>	
24b. REC'D. BY REGISTRAR <i>SEP 16 '59</i>		24c. REGISTRAR'S SIGNATURE <i>Albert S. Kress</i>	
DATE <i></i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician and completely filled in by the medical director.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09764

CERTIFICATE OF DEATH

Reg. Dist. No.

09739

1. PLACE OF DEATH COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 7 HOURS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MARYLAND		d. STREET ADDRESS 100 SEYMOUR STREET						
d. NAME OF HOSPITAL (If not in hospital, give name and address of institution) MEMORIAL HOSPITAL AVES.		WALNUT & MEMORIAL AVES.		d. STREET ADDRESS 100 SEYMOUR STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) KENNETH		First KENNETH	Middle S.	Last FULLER	4. DATE OF DEATH SEPTEMBER 10 1959	Month SEPTEMBER	Day 10	Year 1959				
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JULY 1, 1906	9. AGE (In years last birthday) 53 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. IF UNDER 24 HRS. Min. 0				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist		10b. KIND OF BUSINESS OR INDUSTRY Textile, Yarn		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.						
13. FATHER'S NAME HARRY, FULLER		14. MOTHER'S MAIDEN NAME ELIZABETH KRAUSE										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-07-2965		INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND		Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 411X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) UPPER RESP. INFECTION. OLD RT HEMIPARESIS		CONGESTIVE HEART FAILURE AORTIC INSUFFICIENCY OLD RHEUMATIC HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH 3 days 15 yrs								
DUE TO (c) DUE TO												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 59 GREENE ST CUMBERLAND, MD		DATE SIGNED 9/12/59								
ACTUAL SIGNATURE SG WEISMAN		M.D.										
PHYSICIAN'S NAME (Type) SG WEISMAN												
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-13-59		22c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park		22d. LOCATION (City, town, or county) Cumberland, Md.						
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR SEP 17 '59		24b. REGISTRAR'S SIGNATURE John & Krause						

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18.

09740

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
Allegany County, Md.		Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Lonaconing, Md.		Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STREET ADDRESS	
Lonaconing		Transcanning Roosevelt Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
Wilmuth			Garlit
4. DATE OF DEATH	Month	Day	Year
Sept. 20	1959		
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
m	wh.		4/2/1900
9. AGE (In years last birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
89			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Celanese Corp.		Textile	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Hulton, Mo		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Othea Garlit		Annabel Durst	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
No		214-07-3264	
17. INFORMANT		Address	
Mrs. Wilmuth Garlit "Wife"		Lonaconing, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary occlusion	
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		as atherosclerotic cardiovascular disease	
(b)		Years	
DUE TO			
(c)		arteriosclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Duodenal ulcer			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>March 1953</u> to <u>Sept 1959</u> that I last saw the deceased alive on <u>Sept 1959</u> and that death occurred at <u>2A M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George Eash</u>		ADDRESS (Street, city or town, state) <u>27 Main Street, Lonaconing, Md.</u>	
PHYSICIAN'S NAME (Type) <u>George Eash</u>		DATE SIGNED	
22a. BURIAL, CREMATION, OR OTHER (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/23/59</u>	
22c. NAME OF CEMETERY OR CREMATORIUM <u>St. Marys Cemetery</u>		22d. LOCATION (City, town, or county) <u>Lonaconing, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George Eichhorn</u>		ADDRESS <u>Lonaconing, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Trahan</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the general director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 11mg249 10-1-59 et

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09765

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1/9/1956	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Lillian	Middle Belle	Last Grady
4. DATE OF DEATH	Month Sept.	Day 22,	Year 19 59
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/4/1889
9. AGE (In years lost birthday) 70 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. KIND OF BUSINESS OR INDUSTRY Allegany County Infirmary	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Winfield Porter	14. MOTHER'S MAIDEN NAME Hattie Albright	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. none	17. INFORMANT P.O.Box 599 Allegany County Infirmary Records	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Cardio-Vascular Disease & advanced Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Arterio Sclerosis. (c) Gastric Neuritis -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) 49 Greene St. (State) Cumberland, Md.
21. I certify that I attended the deceased from 1/9/56 , 19, to 9/22/59 , 19, that I last saw the deceased alive on 9/22/59 , 19, and that death occurred at 4:35 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE L. B. Mathews	ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 9/23/59		
PHYSICIAN'S NAME (Type) Dr. L. B. Mathews			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 25, 1959	22c. NAME OF CEMETERY OR CREMATORIUM St. Patricks Cemetery	22d. LOCATION (City, town, or county) (State) Mt. Savage, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland	ADDRESS	24a. REC'D BY REGISTRAR SEP 28 59	24b. REGISTRAR'S SIGNATURE John J. Hafer

CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	DEATH DATE	TIME	CAUSE OF DEATH	DEATH CERTIFICATE NUMBER
WILLIAM H. BROWN	65	Male	APRIL 25, 1919	10:30 P.M.	Heart Disease	18-100000
ADDRESS OF DECEASED						
1015 E. 36th Street, Baltimore, Maryland						
NAME AND ADDRESS OF PHYSICIAN						
Dr. J. E. H. Brown, 1015 E. 36th Street, Baltimore, Maryland						
NAME AND ADDRESS OF FUNERAL DIRECTOR						
John W. Brown, 1015 E. 36th Street, Baltimore, Maryland						
NAME AND ADDRESS OF PERSON REPORTING						
John W. Brown, 1015 E. 36th Street, Baltimore, Maryland						
NAME AND ADDRESS OF PERSON SIGNING						
John W. Brown, 1015 E. 36th Street, Baltimore, Maryland						
SIGNED AND FILED						
APR 26 1919						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician and completely filled in by the funeral director.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09742

09766

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 20 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Emma	Middle Margaret	Last Granlich
4. DATE OF DEATH	Month 9	Day 26	Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-7-1860
9. AGE (In years last birthday) 99	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. KIND OF BUSINESS OR INDUSTRY Own home	12. BIRTHPLACE (State or foreign country) Cumberland, Maryland
13. FATHER'S NAME Richard Bender	14. MOTHER'S MAIDEN NAME Mary Gesner		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	INFORMANT Miss Marie E. Glick	Address Cumb. Md. 243 N. Centre St.,
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Cerebral Vascular Accident, right cerebral hemi- sphere (c) Generalized and Cerebral Arteriosclerosis DUE TO 3 days years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that I attended the deceased from February 1959 , to Sept. 26th, 1959 , that I last saw the deceased alive on Sept. 26th, 1959 , and that death occurred at 12:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Wyand F. Doerner</i>	M.D. Algonquin Hotel, Cumberland, Maryland.	9/27/59	
PHYSICIAN'S NAME (Type) Wyand F. Doerner, Jr., M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/29/59	22c. NAME OF CEMETERY OR CREMATORIY SS. Peter & Paul's	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George	ADDRESS Cumberland, Maryland	24a. REC'D BY REGISTRAR DATE SEP 29 1959	24b. REGISTRAR'S SIGNATURE <i>Editha</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be sent to the Chief Medical Examiner's Office along with farm PMA3. Page 5 may be retained for our files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09743

Reg. Dist. No.

09806

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oldtown		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellerslie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS Gardner Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) KENNETH		First L.	Middle GRIFFEY	Lost	4. DATE OF DEATH Month Sept. Day 26 Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 27, 1892	9. AGE (In years last birthday) 67 yrs.	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Rayon factory		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Charles Griffey		14. MOTHER'S MAIDEN NAME Emma E. Coleman		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214 07 4249		17. INFORMANT Address Linwood Griffey Ellerslie, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO Coronary Occlusion			
Conditions, if any, which gave rise to immediate cause (b), (a), stating the underlying cause lost.		DUE TO Coronary Sclerosis			
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>	M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/26/59	
EXAMINER'S NAME (Type) Benedict Skitarelic, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/29/1959	22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery	22d. LOCATION (City, town, or county) Cumberland, Md.	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Knight	ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR DATE SEP 28 '59	24b. REGISTRAR'S SIGNATURE Orin & Kline		

STATE OF CALIFORNIA
DEPARTMENT OF MOTOR VEHICLES
LOCAL EXAMINERS CERTIFICATE OF DEATH

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09767 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09744

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. LENGTH OF STAY IN 1b c. STREET ADDRESS 02 Cumberland, 627 Frederick St.,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hosp.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS / 627 Frederick St.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JAMES	Middle EDWARD	Last HARPER
4. DATE OF DEATH	Month Sept.	Month 7,	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> July 31, 1869	9. AGE (In years at birthday) 90 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired wood turner		10b. KIND OF BUSINESS OR INDUSTRY Lumber business	
11. BIRTHPLACE (State or foreign country) Gore, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Harper		14. MOTHER'S MAIDEN NAME Mary F. Light	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. Mrs. May H. Minghini	
17. INFORMANT No,		Address Cumberland, Md 627 Frederick St.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 904.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Fracture RT tiff Ravages of age and dealt			
INTERVAL BETWEEN ONSET AND DEATH 5 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia and Bronchitis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II or Item 18.) Fall in bath room -	
20c. TIME OF INJURY Month, Day, Year Hour 2 a. m. p. m. 9/3/59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Cumberland, Md	
(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> R. J. Williams, M.D.			
ACTUAL SIGNATURE		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> (acting)	
EXAMINER'S NAME (Type)		DATE SIGNED 8/3/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/11/59	
22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		22d. LOCATION (City, town, or county) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George Cumberland, Md.		ADDRESS	
24a. REC'D BY REGISTRAR DATE SEP 10 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

DEPARTMENT OF STATE - BUREAU OF INTELLIGENCE - 87

ALL EXAMINER'S CERTIFICATE OF DEATH

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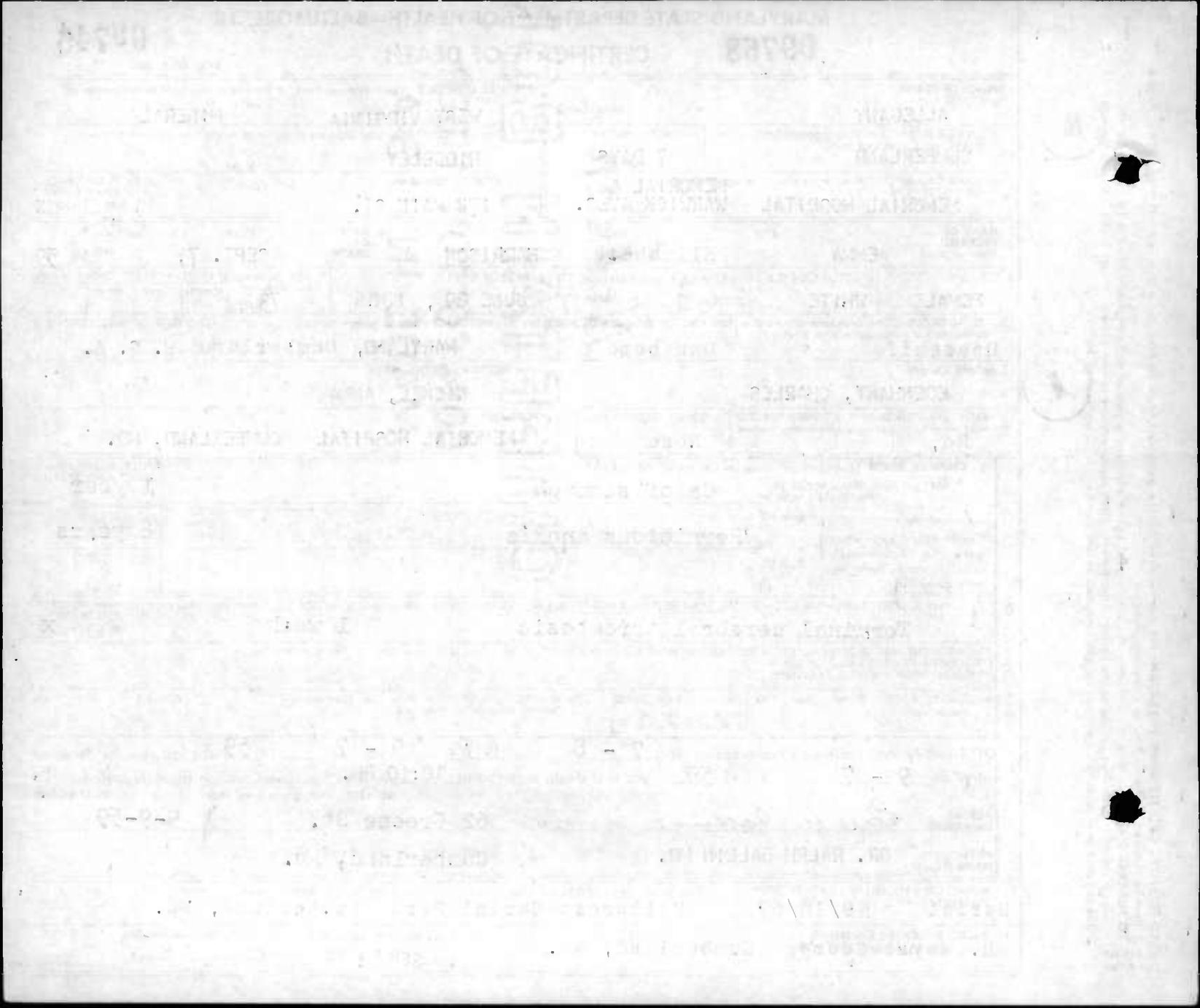
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
09768 CERTIFICATE OF DEATH

09745

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 7 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street and nearest town) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> d. STREET ADDRESS 172 MAIN ST.	
3. NAME OF DECEASED (Type or print) EMMA		First Elizabeth	Middle HARRISON
4. DATE OF DEATH SEPT. 7,		Month 19 59	Day Year
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH JUNE 29, 1886		9. AGE (In years last birthday) 73 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) MARYLAND, Cumberland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME EDENHART, CHARLES		14. MOTHER'S MAIDEN NAME NICKEL, ANNA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ca of stomach DUE TO 151X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Pernicious anemia DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 1 year			
8 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Terminal cerebral thrombosis 1 week			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7 - 8 , 19 54 , to 9 - 7 , 19 59 , that I last saw the deceased alive on 9 - 7 , 19 59 , and that death occurred at 10:10 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Ralph L. Bassin</i>		ADDRESS (Street, city or town, state) 62 Greene St. DATE SIGNED 9-9-59	
PHYSICIAN'S NAME (Type) DR. RALPH BALLIN MD.		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/10/59	
22c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Burial Park		22d. LOCATION (City, town, or county) Cumberland, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR DATE SEP 14 '59
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09746

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		d. STREET ADDRESS Route 4, Mexico Farms		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ERNEST		First E.	Middle HARTMAN, JR.	4. DATE OF DEATH Sept. 29, 1959	Month Day Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Nov. 7, 1922	9. AGE (In years, last birthday) 36 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman		10b. KIND OF BUSINESS OR INDUSTRY W. M. R. R.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Ernest E. Hartman, Sr.		14. MOTHER'S MAIDEN NAME Bertha Beerman		Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 217 18 4865		17. INFORMANT E. E. Hartman, Sr. Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH 10-15 Min			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 825X		Crushed Chest, Ruptured Liver			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Automobile Accident					
DUE TO (b) Automobile Accident					
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile Accident			
20c. TIME OF INJURY Hour o. m. 4:10 — Sept. 29 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Rt. #220 On Rt. 22, Bedford, Pa.	
20g. (County) 88				(State) 2	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		DATE SIGNED 9/30/1959			
EXAMINER'S NAME (Type) Benedict Skitarelic, M. D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 2, 1959		22c. NAME OF CEMETERY OR CREMATORIAL Davis Memorial Cem.	
22d. LOCATION (City, town, or county) Cumberland, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRATION OCT 2 1959	
				24b. REGISTRATION SIGNATURE Author S. Kight	
VS. A15ME 5M 2/57					

WISCONSIN

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09770

CERTIFICATE OF DEATH

09747

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Allegany</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cumberland</i>		c. LENGTH OF STAY IN 1b <i>Life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>511 Richl Ave</i>		e. STREET ADDRESS <i>1511 Richl Ave</i>	
3. NAME OF DECEASED (Type or print) <i>William J. Helmstetter</i>		4. DATE OF DEATH <i>Sept. 24</i>	Month Day Year <i>Sept. 24 1959</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 28 1876</i>
9. AGE (In years less birthday) <i>83</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
13. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Watchman</i>		
10b. KIND OF BUSINESS OR INDUSTRY <i>B & O.</i>		11. BIRTHPLACE (State or foreign country) <i>Cumberland</i>	
13. FATHER'S NAME <i>George Helmstetter</i>		14. MOTHER'S MAIDEN NAME <i>Sabina Raching</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>123-45-6789</i>	
17. INFORMANT <i>Mrs. Bertha Jones</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.2</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <i>(b)</i> DUE TO <i>(c)</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <i>Chronic Myocarditis with Decompensation 6 months</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. <i>19</i>	Month, Day, Year <i>19</i>	20d. INJURY OCCURRED White Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>16 Greene St, Cumberland, Md.</i>
20f. (City or town) <i>Cumberland</i>	(County) <i>Maryland</i>	(State) <i>Md.</i>	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James J. Johnson</i>	ADDRESS (Street, city, or town, state) <i>16 Greene St, Cumberland, Md.</i>		
PHYSICIAN'S NAME (Type) <i>James J. Johnson, Jr.</i>	DATE SIGNED <i>Sept. 29, 1959</i>		
22a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Sept. 29, 1959</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>SS Peter & Paul Cemetery</i>	22d. LOCATION (City, town, or county) <i>Cumberland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Louis Stein Inc. (Cumb. Md.)</i>	ADDRESS <i>16 Greene St, Cumberland, Md.</i>	24a. REC'D BY REGISTRAR DATE <i>SEP 29 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur H. Hause</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of the death.

1

09748

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09771 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 4 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
3. NAME OF DECEASED (Type or print) HERBERT		4. DATE OF DEATH September 7, 1959	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 16, 1912	
9. AGE (In years lost birthday) 47 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEGMAIER'S FARM		10b. KIND OF BUSINESS OR INDUSTRY General Farming	
10c. BIRTHPLACE (State or foreign country) WEST VIRGINIA		11. INFORMANT Keyser	
13. FATHER'S NAME HARRY HIGSON		14. MOTHER'S MAIDEN NAME MAUDE DOUGLING	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 217-10-1277	
17. PART I. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] IMMEDIATE CAUSE (a) 593X		18. INFORMANT WARWICK & MEMORIAL AVES. MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND.	
DUE TO Terminal cardiac failure		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Uremia			
(c) DUE TO Nephritis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/1/1959 to 9/7/1959 that I lost the deceased alive on 9/1/1959 , and that death occurred at 4:10 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Dr. G. M. Simons</i>		ADDRESS (Street, city or town, state) Allegany Hospital 9/11/59	
PHYSICIAN'S NAME (Type) DR. G. M. SIMONS		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 10, 1959	
22c. NAME OF CEMETERY OR CREMATORIAL Mt. Herman Cemetery		22d. LOCATION (City, town, or county) (State) Allegany Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE SEP 11 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE John J. Hafer, Cumberland, Maryland	

GENERAL COUNCIL OF DELEGATES

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18
FOR STATE
HEALTH DEPT.

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PMA. Page 5 may be retained for our files.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09749

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		b. COUNTY Allegany	
c. LENGTH OF STAY IN 1b 50 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS 512 Ridgewood Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First VIRGIL	Middle D.	Last HINKLE
4. DATE OF DEATH	Month Sept. 17,	Day 19	Year 59
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 14, 1897
9. AGE (In years from birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Weighmaster		10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (State or foreign country) Elkins, W. Va.
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Philmore H. Hinkle			
14. MOTHER'S MAIDEN NAME Mary Virginia Wentling			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705 05 8089	17. INFORMANT Mrs. Juanita McKenzie, Cumberland, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Coronary Thrombosis 30 minutes Coronary Artery disease = Arteriosclerosis =			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 10 a.m. 9/17/59		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cassock Alley Md
20f. (City or town) Cassock Alley Md		(County) Allegany	(State) Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>DJ McNamee</i>		DATE SIGNED 9/17/59	
EXAMINER'S NAME (Type) Byron Kight		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> acting	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 20, 1959	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Davis Memorial Cem. Cumberland, Md.
22d. LOCATION (City, town, or county) Cumberland, Md.		24a. REC'D BY REGISTRAR Arthur S. Krause	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	
VS. A1SM SM 2/57		DATE SEP 21 '59	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09796

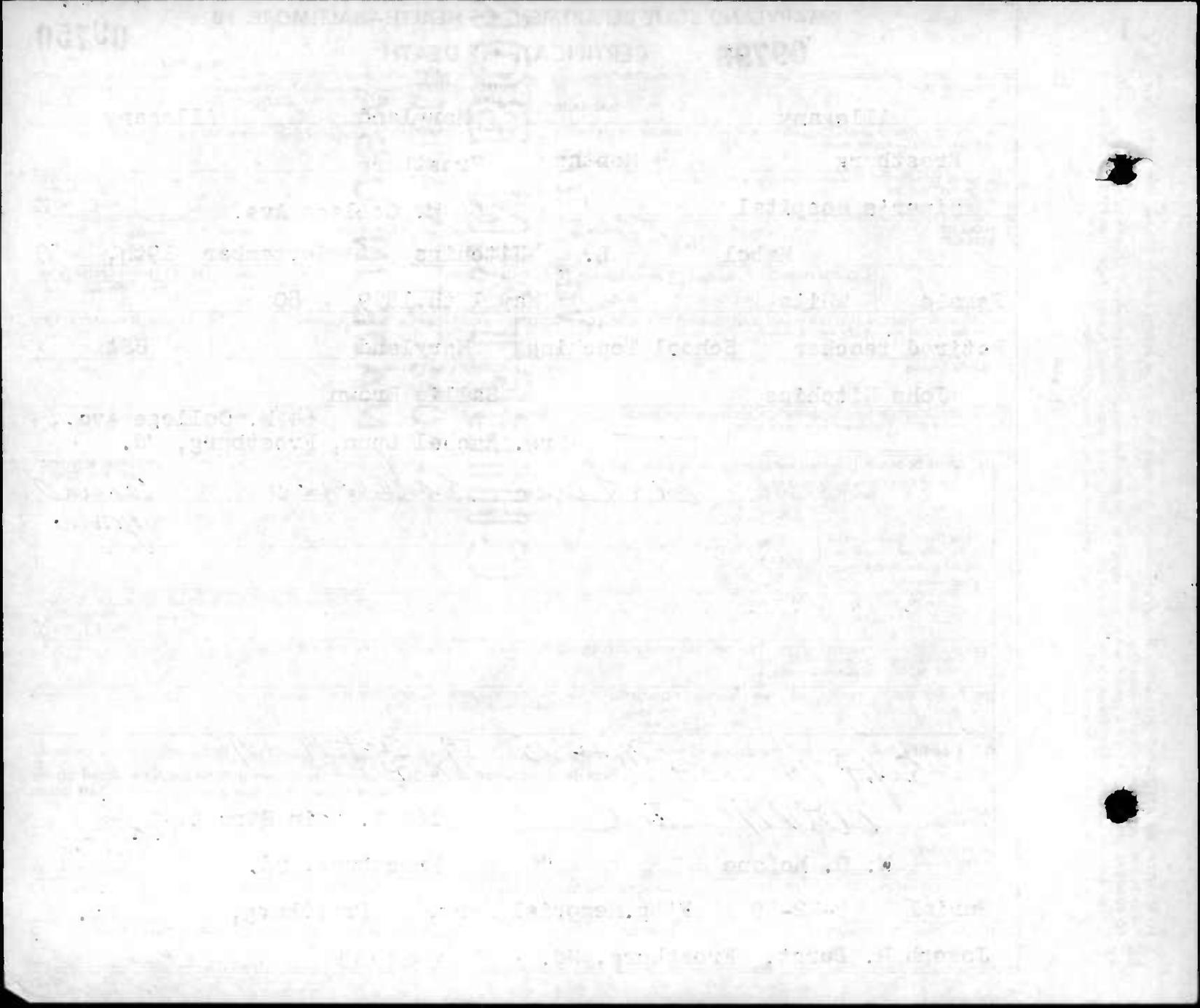
CERTIFICATE OF DEATH

Reg. Dist. No.

09750

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 4 Months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miner's Hospital		22. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
3. NAME OF DECEASED (Type or print) Mabel		d. STREET ADDRESS 66 W. College Ave.	
4. DATE OF DEATH Month September		Day Year 19th, 1959	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH May 17th, 1879	
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired teacher		10b. KIND OF BUSINESS OR INDUSTRY School Teaching	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Hitchins		14. MOTHER'S MAIDEN NAME Sallie Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 450.0		16. SOCIAL SECURITY NO. 64 W. College Ave., Mrs. Rachel Dunn, Frostburg, Md.	
17. INFORMANT Arterio Sclerosis		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 450.0 (b) DUE TO (c)	
19. INTERVAL BETWEEN ONSET AND DEATH several years		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Part II. Other significant conditions contributing to death but not related to the terminal disease condition given in Part I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 15, 1959 to Sept 19, 1959 , that I last saw the deceased alive on Sept 19, 1959 , and that death occurred at 167 E. Main Street, Frostburg, Md. from the causes and on the date stated above. ACTUAL SIGNATURE W. O. McLane		ADDRESS (Street, city or town, state) 167 E. Main Street, Frostburg, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-22-59	
22c. NAME OF CEMETERY OR CREMATORIAL F'bg. Memorial Park,		22d. LOCATION (City, town, or county) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst, Frostburg, Md.		24a. REC'D BY REGISTRAR SEP 23 '59	
ADDRESS Joseph R. Durst, Frostburg, Md.		24b. REGISTRAR'S SIGNATURE John S. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09773

CERTIFICATE OF DEATH

Reg. Dist. No.

09751

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland.		c. LENGTH OF STAY IN 1b 02	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 801 Mann's Terrace		e. STREET ADDRESS 801 Mann's Terrace	
3. NAME OF DECEASED (Type or print) First ELLA Middle ISABELLE Last HOLTZHOUR		4. DATE OF DEATH Sept. 10, 1959	Month Day Year
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	B. DATE OF BIRTH Nov. 18, 1873
8. AGE (In years (at birthday) yrs. 85		9. IF UNDER 1 YEAR Months 0	10. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Sunbury, Penna.
13. FATHER'S NAME John Clymer		14. MOTHER'S MAIDEN NAME Catherine A. Holter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) No,		16. SOCIAL SECURITY NO. None	17. INFORMANT Mr. Clifton J. Goodrich
		Address 801 Mann's Terrace	Cumberland, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal cardiac failure DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Hypertension and arteriosclerosis (had disease 5 years DUE TO (c) Sen. arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 24 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 15 June , 1955, to 10 Sept. , 1959, that I last saw the deceased alive on 9 Sept. , 1959, and that death occurred at 4:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 122 So. Centre St.		DATE SIGNED 11 Sept. 59	
ACTUAL SIGNATURE W. Alfred Van Ormer		M.D.	
PHYSICIAN'S NAME (Type) W. A. VanOrmer M.D.		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/13/59	22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR DATE SEP 14 '59
			24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

1
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be retained by the hospital or attending physician.

2
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 18 Film 248 9-9-59 ams
09774 CERTIFICATE OF DEATH
Reg. Dist. No. 09752

PLACE OF DEATH C. COUNTY ALLEGANY			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 5 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL & MEMORIAL HOSPITAL-WARWICK AVES.		d. STREET ADDRESS 732 BAKER STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First BABY	Middle BOY	Last HUFFMAN	4. DATE OF DEATH SEPTEMBER 1, 1959	Month Day Year			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 31, 1959		9. AGE (In years last birthday) yrs. 5	10. IF UNDER 1 YEAR Months 5	11. IF UNDER 24 HRS. Days 35	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME BURREL HUFFMAN			14. MOTHER'S MAIDEN NAME GEORGIA J. ROTRUCK					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND.		17. WARWICK & MEMORIAL AVES.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO A miotic (Meconium) synphysis (b) DUE TO entire lung parenchyma (c) Patent ductus arteriosus? INTERVAL BETWEEN ONSET AND DEATH 5 hr								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from olive on Sept 1, 1959 , and that death occurred at 2:45 AM from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Cumberland, Md.						
ACTUAL SIGNATURE DR. Hodges		DATE SIGNED 9/1/59						
PHYSICIAN'S NAME (Type) DR. HODGES & MOULD.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-1-1959		22c. NAME OF CEMETERY OR CREMATORIUM Huffman Family Cemetery Flintstone, Md.		22d. LOCATION (City, town, or county) (State)		
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE SEP 3 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Keas		

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1
FOR STATE
HEALTH DEPT.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2
VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
09807 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09753
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. # 1 Cumberland,		b. COUNTY Allegany	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rt. # 1 Cumberland,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Valley Road		d. STREET ADDRESS Valley Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First EMMA	Middle MARIA	Last IMLER
4. DATE OF DEATH	Month Sept.	Day 10,	Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 4, 1863
9. AGE (In years last birthday) 95 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Bedford Co. Penna.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Daniel Dibert		14. MOTHER'S MAIDEN NAME Maria Croyle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Agnes Hensley, Rt. # 1 Cumberland,		Address Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis Rheages of age			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumberland, Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R. J. Williams M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9/10/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/12/59	
22c. NAME OF CEMETERY OR CREMATORIAL Pleasant Valley Cem.		22d. LOCATION (City, town, or county) Nr. Bedford, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George Cumberland, Md.		24a. REC'D BY REGISTRAR DATE SEP 14 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur & Krause	

STATE OF SOUTH DAKOTA
DEPARTMENT OF HEALTH - DIVISION OF
MEDICAL EXAMINERS CERTIFICATE OF DEATH

STATE OF
SOUTH DAKOTA

Natural Accidental Homicide Suicide
 Disease Injury Death from Death due to
 unknown unknown unknown unknown

Decedent's name

Place of residence

Place of death

Time of death

Date of death

Age at death

Sex at death

Color of hair

Color of eyes

Color of skin

Yes No Yes No Yes No Yes No
 Yes No Yes No Yes No Yes No

1.

2.

3.

4.

5.

Signature

Printed Name

Address

City

State

Date

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09775

CERTIFICATE OF DEATH

Reg. Dist. No.

09754

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RT. # 5 Cumberland,	
3. NAME OF DECEASED (Type or print) TOLIVER WADE		d. STREET ADDRESS Cresap Park	
4. DATE OF DEATH SEPT. 23 1959		Month	Day
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 13, 1880	
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
11. BIRTHPLACE (State or foreign country) Rockingham Co. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EMANUEL JEWELL (DECEASED)		14. MOTHER'S MAIDEN NAME Susan Zoughlin (DECEASED)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. 217-10-6677	
17. INFORMANT Mr. Lester L. Jewell		18. ADDRESS 937 Md. Ave., Cumb. Md.	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterosclerotic heart disease			
DUE TO 420.0			
INTERVAL BETWEEN ONSET AND DEATH 1 year			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Generalized arteriosclerosis			
DUE TO 420.0			
INTERVAL BETWEEN ONSET AND DEATH 2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cumberland (County) Maryland (State) Md.	
21. I certify that I attended the deceased from 4-3- , 1957, to 9-23- , 1957, that I last saw the deceased alive on 4-23- , 1957, and that death occurred at 11:00 P.M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) Lewis Brings, M.D.			
DATE SIGNED 9-25-57			
ACTUAL SIGNATURE Lewis Brings		M.D.	
PHYSICIAN'S NAME (Type) Lewis Brings, M.D.		55 GREENE ST., CUMBERLAND, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/26/59	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR SEP 28 '59		24b. REGISTRAR'S SIGNATURE Charles E. Brings	

CELESTE CARD

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
09776 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09755

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 35 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 02		d. STREET ADDRESS 1804 Oldtown Road		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1804 Oldtown Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Effie		First Caroline	Middle Kellar	4. DATE OF DEATH Sept. 7,	Month 1959	Day	Year	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 17, 1886	9. AGE (In years last birthday) 72 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Salem, W.Va.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Geo. A. Davis		14. MOTHER'S MAIDEN NAME Melvina Boyce		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Beryl E. Kellar		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Coronary Thrombosis Coronary Sclerosis		INTERVAL BETWEEN ONSET AND DEATH 8 hrs
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE 		EXAMINER'S NAME (Type) Richard J. Williams, MD		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> (acting)		DATE SIGNED 8/7/59		
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 9-10-1959		22c. NAME OF CEMETERY OR CREMATORIUM Zion Memorial Park		22d. LOCATION (City, town, or county) Cumberland, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE SEP 10 '59		24b. REGISTRAR'S SIGNATURE C. Scarpelli & Sons		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for future files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATEMENT OF
ECONOMIC-INDUSTRIAL STATE OF ALASKA
HEAD OF STATE GOVERNMENT OF ALASKA

STATE GOV
1947

ITEM	DESCRIPTION	ITEM
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

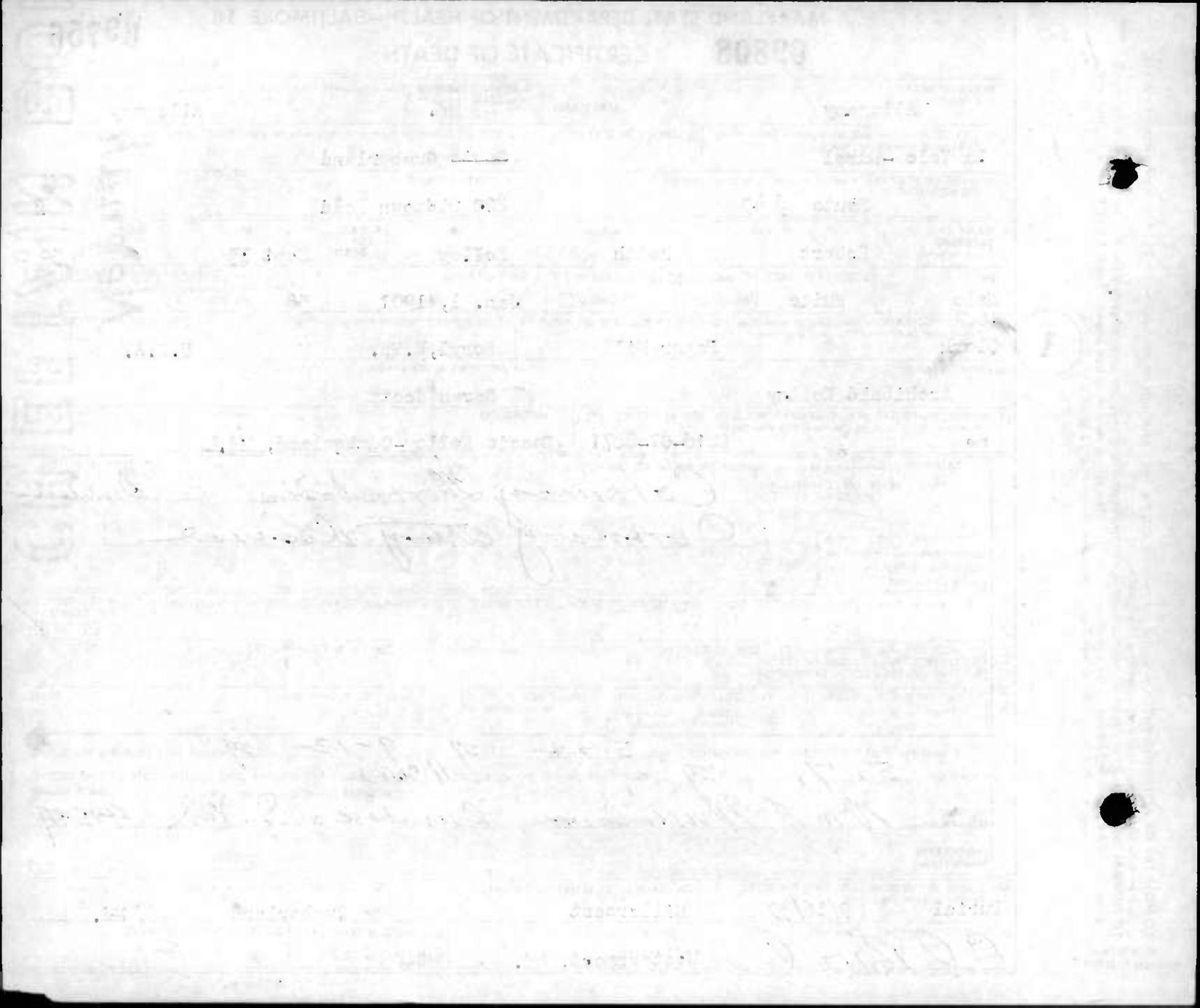
09808

CERTIFICATE OF DEATH

09756

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Vale -Rural		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Park Cumberland				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route # 40				d. STREET ADDRESS 820 Oldtown Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Robert		First	Middle	Last	4. DATE OF DEATH Sept 13	Month	Day	Year 19 59
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Jan. 1, 1901	9. AGE (In years lost birthday) 58 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Paper Mill		11. BIRTHPLACE (State or foreign country) Beryl, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Archibald Kelley			14. MOTHER'S MAIDEN NAME Sarah Scott					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-07-8871		INFORMANT Bessie Kelley-Cumberland, Md.		Address		
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p> <p>Coronary Thrombosis Coronary artery disease</p> <p>INTERVAL BETWEEN ONSET AND DEATH Sudden</p>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.		Month, Doy, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Cumberland	(County)	(State) Md.	
<p>21. I certify that I attended the deceased from <u>5-24</u>, 19<u>59</u>, to <u>9-13</u>, 19<u>59</u> that I last saw the deceased alive on <u>5-7</u>, 19<u>59</u>, and that death occurred at <u>11300</u> from the causes and on the date stated above.</p> <p>ACTUAL SIGNATURE <u>Wm. F. Williams</u> M.D. ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED <u>9-15-59</u></p>								
PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/16/59	22c. NAME OF CEMETERY OR CREMATORIUM Hillcrest			22d. LOCATION (City, town, or county) Cumberland		
23. FUNERAL DIRECTOR'S SIGNATURE <u>S. Boral</u>		ADDRESS Westernport, Md.			24a. REC'D BY REGISTRAR DATE SEP 17 '59	24b. REGISTRAR'S SIGNATURE <u>Calvert & Knott</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09777

CERTIFICATE OF DEATH

09757

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 3/16/59		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Clara	Middle Lillian	Last Kerber	
4. DATE OF DEATH	Month September	Day 10	Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/11/1873	
9. AGE (In years (last birthday) 85 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Frostburg, Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Beane	14. MOTHER'S MAIDEN NAME Kathrynn Brennan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,	16. SOCIAL SECURITY NO. None	17. INFORMANT P.O. Box 599	Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Pulmonary Hypertension. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Chronic myocardial Degeneration DUE TO (c) General arteriosclerosis. DUE TO ? ? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Osteoarthritis. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3/16/59 , 19____, to 9/10/59 , 19____, that I last saw the deceased alive on 9/10/59 , 19____, and that death occurred at 7:05 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE James E. McLean M.D. 49 Greene St. 9/11/59				
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Md.		
22a. BURIAL, CREMATION OR REMOVAL (Specify) Burial	22b. DATE THEREOF 9/12/59	22c. NAME OF CEMETERY OR CREMATORIAL SS. Peter & Paul's	22d. LOCATION (City, town, or county) Cumberland, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George			24a. REC'D BY REGISTRAR DATE SEP 14 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Knob

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09797

CERTIFICATE OF DEATH

Reg. Dist. No.

09758

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg,		c. LENGTH OF STAY IN lb 25 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		d. STREET ADDRESS 54 Ormand Street			
d. NAME OF HOSPITAL (If not in Hospital, give street address) OR INSTITUTION 54 Ormand Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Joseph		First T.	Middle Kidwell	Last Kidwell	4. DATE OF DEATH Sept. 18th, 1959	Month Sept.	Day 18th	Year 1959	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH May 10th, 1911	9. AGE (In years last, birthday) 48 yrs.	IF UNDER 1 YEAR Months 54	IF UNDER 24 HRS. Days Ormand St.,	Hours Frostburg, Md.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman-Spinning		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Kidwell				14. MOTHER'S MAIDEN NAME Janet Gracie					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 420.1		16. SOCIAL SECURITY NO. 214-07-5355		INFORMANT Mrs. Margaret Kidwell, Frostburg, Md.		. Address 54 Ormand St.,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial dilatation						INTERVAL BETWEEN ONSET AND DEATH 20 min			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Coronary塞子		DUE TO (b) DUE TO (c)				?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Frostburg		(County) Frostburg	(State) Md.
21. I certify that I attended the deceased from Sept 18, 1959 , to Sept 18, 1959 , that I last saw the deceased alive on Sept 18, 1959 , and that death occurred at 8:30 AM , from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>WOM</i> <i>WOM</i>		M.D.		ADDRESS (Street, city or town, state) Frostburg		DATE SIGNED Sept 18, 1959			
PHYSICIAN'S NAME (Type) <i>WOM</i> <i>WOM</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-21-59		22c. NAME OF CEMETERY OR CREMATORIAL F' bg. Memorial Park		22d. LOCATION (City, town, or county) Frostburg, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst, Frostburg, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE SEP 21 '59		24b. REGISTRAR'S SIGNATURE Arthur & Krause			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09759

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the medical director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 19 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR IN MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND	
e. STREET ADDRESS 120 LAING AVENUE		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RACHEL		First C.	Middle KROWE
4. DATE OF DEATH SEPT. 17 1959	Month Day Year		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOVEMBER 13, 1876
9. AGE (In years last birthday) 82 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper	11. KIND OF BUSINESS OR INDUSTRY At Home	12. BIRTHPLACE (State or foreign country) WEST VIRGINIA
13. FATHER'S NAME HENRY SIMONS	14. MOTHER'S MAIDEN NAME SARA SIMONS		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	INFORMANT MEMORIAL HOSPITAL	Address CUMBERLAND, MARYLAND
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (c) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.			
Uremia			
Chronic Congestive Failure Generalized Arteriosclerosis			
INTERVAL BETWEEN ONSET AND DEATH 1 wk			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9-13, 1959, to 9-17, 1959, that I last saw the deceased alive on 9-17-59, 1959, and that death occurred at 3:40 P.M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) 445 1/2 Center St Cumberland			
DATE SIGNED 9-18-59			
ACTUAL SIGNATURE William R. James	M.D.		
PHYSICIAN'S NAME (Type) DR. OVERTON HUMMELWRIGHT	Cumberland		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/20/59	22c. NAME OF CEMETERY OR CREMATORIUM Sunset Memorial Park	22d. LOCATION (City, town, or county) (State) Cumberland Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox	ADDRESS Cumberland Maryland	24a. REC'D BY REGISTRAR DATE SEP 24 '59	24b. REGISTRAR'S SIGNATURE Arthur J. Traue

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reuse carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09779

CERTIFICATE OF DEATH

Reg. Dist. No.

09760

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W.V.A.		b. COUNTY Mineral					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgeley		d. STREET ADDRESS 85 X-3					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		d. STREET ADDRESS 12 Jones St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Regina	Middle Lucille	Last Lechliter	4. DATE OF DEATH	Month Sept.	Day 20	Year 1959			
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 30, 1943	9. AGE (In years Incl. birthday) 15 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. IF UNDER 24 HRS. Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME George D. Shaffer		14. MOTHER'S MAIDEN NAME Mary Jones		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Mr. John L. Lechliter		Address Ridgeley, W.Va	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 951X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- } lying cause last. } (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) 9/15		(County) 1959		(State) 9/20	
21. I certify that I attended the deceased from 9/20 , 1959, to 9/20 , 1959, that I last saw the deceased alive on 9/20 , 1959, and that death occurred at 4:50 P.M. from the causes and on the date stated above.											
ACTUAL SIGNATURE <i>Dr. Leo H. Ley</i>		PHYSICIAN'S NAME (Type) Dr. Leo H. Ley		M.D.		ADDRESS (Street, city or town, state) 446 N. Centre St.		DATE SIGNED 9/21/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/23/59		22c. NAME OF CEMETERY OR CREMATORIUM Zion Memorial Cem.		22d. LOCATION (City, town, or county) Kumberland, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.		24a. REC'D. BY REGISTRAR SEP 24 1959		24b. REGISTRAR'S SIGNATURE <i>John H. Lewis</i>					
VS A15 (4) 15M 9/58											

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09798

CERTIFICATE OF DEATH

09761

Reg. Dist. No.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b 70 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 42 LINDEN ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARION	First MARION	Middle G.	Last LEWIS
4. DATE OF DEATH SEPT. 25, 1959	Month SEPT.	Day 25	Year 1959
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 10, 1866
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) WALES		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DAVID GRIFFITH		14. MOTHER'S MAIDEN NAME MARY YATES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT GRIFFITH LEWIS, FROSTBURG, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterial Sclerosis</i> DUE TO <i>45.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. INTERVAL BETWEEN ONSET AND DEATH <i>3 years</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>FROSTBURG, MD.</i> (County) <i>W. M. C. Lane</i> (State) <i>MARYLAND</i>	
21. I certify that I attended the deceased from <i>Sept 25, 1959</i> , to <i>Sept 25, 1959</i> , that I last saw the deceased alive on <i>Sept 25, 1959</i> , and that death occurred at <i>7:15 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W. O. McLane</i>		ADDRESS (Street, city or town, state) E. MAIN ST., FROSTBURG, MD. DATE SIGNED <i>Sept 26, 1959</i>	
PHYSICIAN'S NAME (Type) W. O. McLANE, M. D.		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
22b. DATE THEREOF SEPT. 28 '59		22c. NAME OF CEMETERY OR CREMATORIAL F'BG. MEMORIAL PARK	
22d. LOCATION (City, town, or county) FROSTBURG, MD.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE T. R. DURST, FROSTBURG, MD.		24a. REC'D BY REGISTRAR DATE SEP 28 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09762

09780

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 608 Columbia Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 608 Columbia Avenue				d. STREET ADDRESS 608 Columbia Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Mollie	Middle	Last Maihl	4. DATE OF DEATH	Month Sept.	Day 24	Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 20, 1874		9. AGE (In years last birthday) 85 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Maihl		14. MOTHER'S MAIDEN NAME Margaret Dietrich					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO.	17. INFORMANT	Address Miss Mamie Dietrich, Cumberland, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO							
DUE TO Cortenosebrosis (c)							
INTERVAL BETWEEN ONSET AND DEATH 6 weeks 10 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 22, 1959 , to Sept. 24, 1959 , that I last saw the deceased alive on Sept. 22, 1959 , and that death occurred at 11:35 AM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 236 Virginia Ave. DATE SIGNED 9-25-1959							
ACTUAL SIGNATURE Clay E. Durrett							
PHYSICIAN'S NAME (Type)		Clay E. Durrett, MD		Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-29-1959		22c. NAME OF CEMETERY OR CREMATORIUM SS. Peter & Paul Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR DATE SEP 29 '59		24b. REGISTRAR'S SIGNATURE Arthur & Trans	
James F. Scarnelli, Cumberland, Md.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09781

CERTIFICATE OF DEATH

Reg. Dist. No. 09763

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. LENGTH OF STAY IN 1b RURAL and give nearest town Cumberland,		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 513 Rose Hill Ave.,		e. STREET ADDRESS 513 Rose Hill Ave.,		
3. NAME OF DECEASED (Type or print) MAUDE		First ESSIE	Middle MATHEWS	
4. DATE OF DEATH Sept. 24, 1959	Month Day Year			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH Oct. 10, 1893	
9. AGE (In years lost birthday) 65	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	
13. FATHER'S NAME Emory D. Gray	14. MOTHER'S MAIDEN NAME Fannie M. Benner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,	16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Myrtle Brode	Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO 1810 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Urinary Bladder DUE TO (c)				
INTERVAL BETWEEN ONSET AND DEATH 6 Months				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 126 N. Smallwood St., Cumberland, Md.	20f. (City or town) Cumberland	(County) Md.	(State)
21. I certify that I attended the deceased from Aug. 31, 1959 , to Sept. 24, 1959 , that I last saw the deceased alive on Sept. 24, 1959 , and that death occurred at 7:55 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 126 N. Smallwood St., Cumberland, Md.				
DATE SIGNED 25 Sept 59				
ACTUAL SIGNATURE L. Michael Glick, M.D.				
PHYSICIAN'S NAME (Type) L. Michael Glick, M.D.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/27/59	22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park	22d. LOCATION (City, town, or county) Cumberland, Md.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George	ADDRESS Cumberland, Maryland	24e. REC'D BY REGISTRAR DATE SEP 28 '59	24b. REGISTRAR'S SIGNATURE Orlina & Kraus	

CERTIFICATE OF DEATH

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09782

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 20 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NIKEP			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SAMUEL		First	Middle	Last MC CUTCHEON	4. DATE OF DEATH SEPTEMBER 3	Month 19 59	Day Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH MAY 17 1884	9. AGE (In years less birthday) yrs. 75	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL MC CUTCHEON		14. MOTHER'S MAIDEN NAME FANNY JACOBS					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular Accident (Embolus) INTERVAL BETWEEN ONSET AND DEATH Immediate 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Aricular Fibrillation ?? DUE TO (c) Coronary Arteriosclerosis; Myocardial Fibrosis ?? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Had Cerebro Vascular Accident (embolus) August 14, 1959 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Had Cerebro Vascular Accident (embolus) August 14, 1959					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Cumberland,	(County) Maryland (State)
21. I certify that I attended the deceased from August 14, 1959 , to September 3, 1959 , that I last saw the deceased alive on September 3, 1959 , and that death occurred at 11:40 AM the causes and on the date stated above. ADDRESS (Street, city or town, state) 50 Pershing Street DATE SIGNED 9/11/59							
ACTUAL SIGNATURE 	M.D.						
PHYSICIAN'S NAME (Type) Dr. Samuel Jacobs							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9.6.1959	22c. NAME OF CEMETERY OR CREMATORIY Laurel Hill Cemetery	22d. LOCATION (City, town, or county) Moscow, MD.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN		ADDRESS LONACONING, MD.	24a. REG'D BY REGISTRAR SEP 8 1959	24b. REGISTRAR'S SIGNATURE C. Eichhorn & Sons			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09799 CERTIFICATE OF DEATH

09765

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		b. COUNTY Allegany	
c. LENGTH OF STAY IN 1b "Rural"		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		d. STREET ADDRESS /	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William		First Middle McNeil	4. DATE OF DEATH September 14 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 8, 1873
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Hampshire, W. Va	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William McNeil		14. MOTHER'S MAIDEN NAME Elizabeth O'Neil	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. 364-07-4086	
17. INFORMANT Leo McNeil		Address Klondike, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 wks.	
Cardiac Failure		Cardiovascular Renal Disease months	
Partial Gastrointestinal			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 14</u> , 1959, to <u>Sept 17</u> , 1959, that I last saw the deceased alive on <u>Sept 14</u> , 1959, and that death occurred at <u>4:25 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) John B. Davis, M.D. 2 Broadway Frostburg, Md. DATE SIGNED 9/17/59	
ACTUAL SIGNATURE John B. Davis, M.D.		22. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 9/16/59		22c. NAME OF CEMETERY OR CREMATORIAL Memorial Park	
22d. LOCATION (City, town, or county) Frostburg, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, Maryland	24a. REC'D BY REGISTRAR DATE SEP 17 '59
		24b. REGISTRAR'S SIGNATURE Arthur S. Knue	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

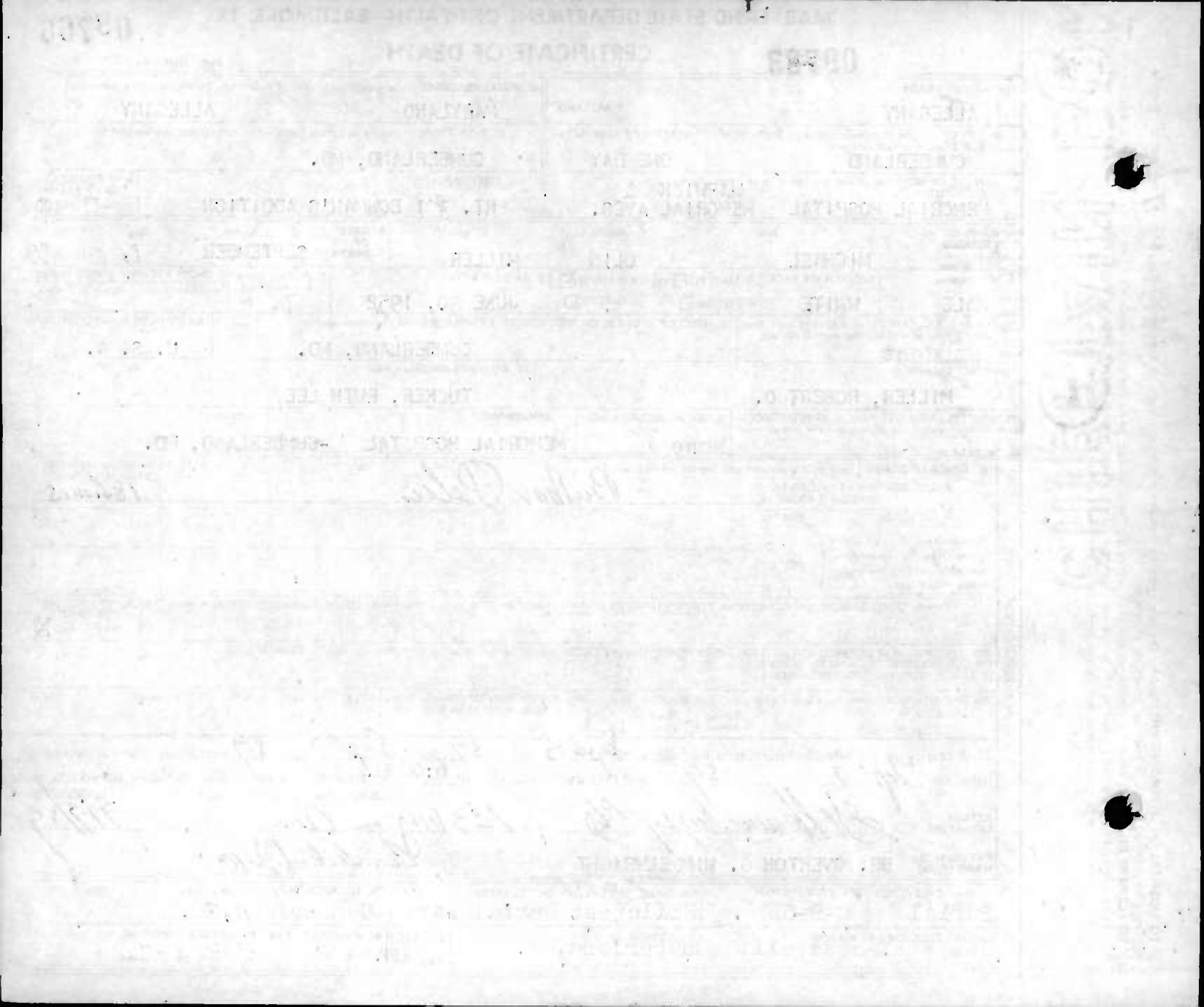
09766

09783

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b ONE DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.		d. STREET ADDRESS RT. #1 BOWMAN'S ADDITION			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WARWICK & MEMORIAL HOSPITAL		MEMORIAL AVES.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) MICHAEL		First OLIN	Middle MILLER	Last MILLER	4. DATE OF DEATH SEPTEMBER 7, 1959	Month SEPTEMBER	Day 7	Year 1959	
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH JUNE 30, 1952	9. AGE (In years last birthday) 7 yrs.	IF UNDER 1 YEAR Months 7	IF UNDER 24 HRS. Days 7	Hours 060	Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME MILLER, ROBERT O.				14. MOTHER'S MAIDEN NAME TUCKER, RUTH LEE					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		INFORMANT MEMORIAL HOSPITAL		Address -CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 080.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 18 hours									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.		Month Sept 5	Day 19	Year 1959	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 133 Virginia Ave	20f. (City or town) Cumberland, Md.	(County) Cumberland, Md.	(State) Md.
21. I certify that I attended the deceased from Sept 5, 1959 to Sept 7, 1959 , that I last saw the deceased alive on Sept 7, 1959 , and that death occurred at 6:00PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md.									
ACTUAL SIGNATURE <i>John G. Himmelwright</i>		DATE SIGNED 9/9/59							
PHYSICIAN'S NAME (Type) DR. OVERTON G. HIMMELWRIGHT									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-9-59		22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		22d. LOCATION (City, town, or county) Cumberland, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE SEP 14 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Krause		



1 FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09767

Reg. Dist. No. 1

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, near Cumberland		c. LENGTH OF STAY IN 1b 3 mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, near Cumberland		d. STREET ADDRESS Route 4, Willowbrook Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 4, Willowbrook Road							
3. NAME OF DECEASED (Type or print) CHARLES	First MAXWELL	Middle MITCHELL	Last 	4. DATE OF DEATH September 14	Month September	Day 19	Year 59
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH Nov. 3, 1932	9. AGE (In years last birthday) 26	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Textile Wkr.		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp. of Cumberland, Maryland		11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas M. Mitchell		14. MOTHER'S MAIDEN NAME Mary Davis					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 215-26-9892		17. INFORMANT Mrs. Mary Davis		Address Rt. 4 Cumberland, Md	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 976 x		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] DUE TO clutra Cranial Damage		INTERVAL BETWEEN ONSET AND DEATH clutra Cranial Damage			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. —		(b) DUE TO by gun shot wound		—		—	
(c) —							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Gun shot wound head -		20c. TIME OF INJURY Month, Day, Year 9/14/59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) At Home	
				20f. (City or town) Cumberland, Md		(County) Allegany	
						(State) Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Richard J. Williams		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Sept. 15, 1959	
EXAMINER'S NAME (Type) Richard J. Williams		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/19/59		22c. NAME OF CEMETERY OR CREMATORIAL Sunset Mem. Park		22d. LOCATION (City, Town, or county) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR SEP 17 '59		24b. REGISTRAR'S SIGNATURE John J. Hafer	

O DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending". Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

O FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15MB
FM 2/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09810

CERTIFICATE OF DEATH

Reg. Dist. No. 09768

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		b. COUNTY Allegany	
c. LENGTH OF STAY IN lb 78 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Castle Street		d. STREET ADDRESS Castle Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CHARLES		First KINGSLEY	Middle MORGAN
4. DATE OF DEATH 9/13/1959		Month 9	Day 13
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH 10/31/1880
8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years lost birthday) 78 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipefitter		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Lonaconing, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Esau Morgan		14. MOTHER'S MAIDEN NAME Rebecca Rinker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-07-2720	
17. INFORMANT Mrs. Nellie Morgan, Lonaconing, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH — Coronary Occlusion, massive Arteriosclerosis years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Congestive Heart Failure		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Dec. (County) 1959 (State)	
21. I certify that I attended the deceased from Sept. 3, 1959 , to Sept. 14, 1959 , that I last saw the deceased alive on Sept. 3, 1959 , and that death occurred at 14, M. from the causes and on the date stated above. ACTUAL SIGNATURE Leslie R. Miles, Jr. M.D.		ADDRESS (Street, city or town, state) LONA CONING DATE SIGNED 9-14-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/15/1959	
22c. NAME OF CEMETERY OR CREMATORIUM Oak Hill Cemetery		22d. LOCATION (City, town, or county) Lonaconing, MD. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN		24a. REC'D BY REGISTRAR DATE SEP 15 '59	
ADDRESS LONA CONING, MD.		24b. REGISTRAR'S SIGNATURE Charles G. Evans	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09800

CERTIFICATE OF DEATH

09769

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miner's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Mae	Middle Desmond	Last Muir
4. DATE OF DEATH	Month September	Day 28th	Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH Jan. 10th, 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own housework	
10c. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Willison		14. MOTHER'S MAIDEN NAME Agnes Walkinshaw	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 214-05-9925	
17. INFORMANT Melvin Muir,		Address Eckhart, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral accident 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic Cardio-vascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 3 Weeks 422.1			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 47 to September , 19 59 that I last saw the deceased alive on September, 1959 , and that death occurred at 2:55 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2 Broadway, DATE SIGNED John B. Davis , M.D. ACTUAL SIGNATURE			
PHYSICIAN'S NAME (Type) John B. Davis		11 Frostburg, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 1st, 59	22c. NAME OF CEMETERY OR CREMATORIAL Eckhart Cemetery	22d. LOCATION (City, town, or county) (State) Eckhart, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst, Frostburg, Md.		24a. REC'D BY REGISTRAR DATE OCT 2 '59	
		24b. REGISTRAR'S SIGNATURE Arthur H. Davis	

60000

ЧИСЛО ПРИДАЧИ 00000

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09770

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital				d. STREET ADDRESS 717 North Mechanic Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First John	Middle Raphael	Last Nee	4. DATE OF DEATH September 20 1959	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 20, 1900	9. AGE (In years last birthday) 59 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brewery Worker		10b. KIND OF BUSINESS OR INDUSTRY Cumberland Brew-		11. BIRTHPLACE (State or foreign country) Cumberland, Maryland	
13. FATHER'S NAME John Stephen Nee		14. MOTHER'S MAIDEN NAME Lucy O'Donnell		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-05-4830		17. INFORMANT Mrs. Dorothy Nee Cumberland, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		Coronary Insufficiency and Occlusion, Marked years....			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO Arteriosclerosis			
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
Occlusion of Iliac vessels due to atheromatous material.		Died in Surgery.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile accident			
20c. TIME OF INJURY Month, Day, Year Hour 10:00 p. m. Sept. 19 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. #40	
20f. (City or town) Town Hill		(County) Alleg.		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 23, 1959		22c. NAME OF CEMETERY OR CREMATORIUM St. Peter & Pauls Cen	
22d. LOCATION (City, town, or county) Cumberland, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS		24a. REC'D BY REGISTRAR SEP 23 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2. See: birth Cert. et

09771

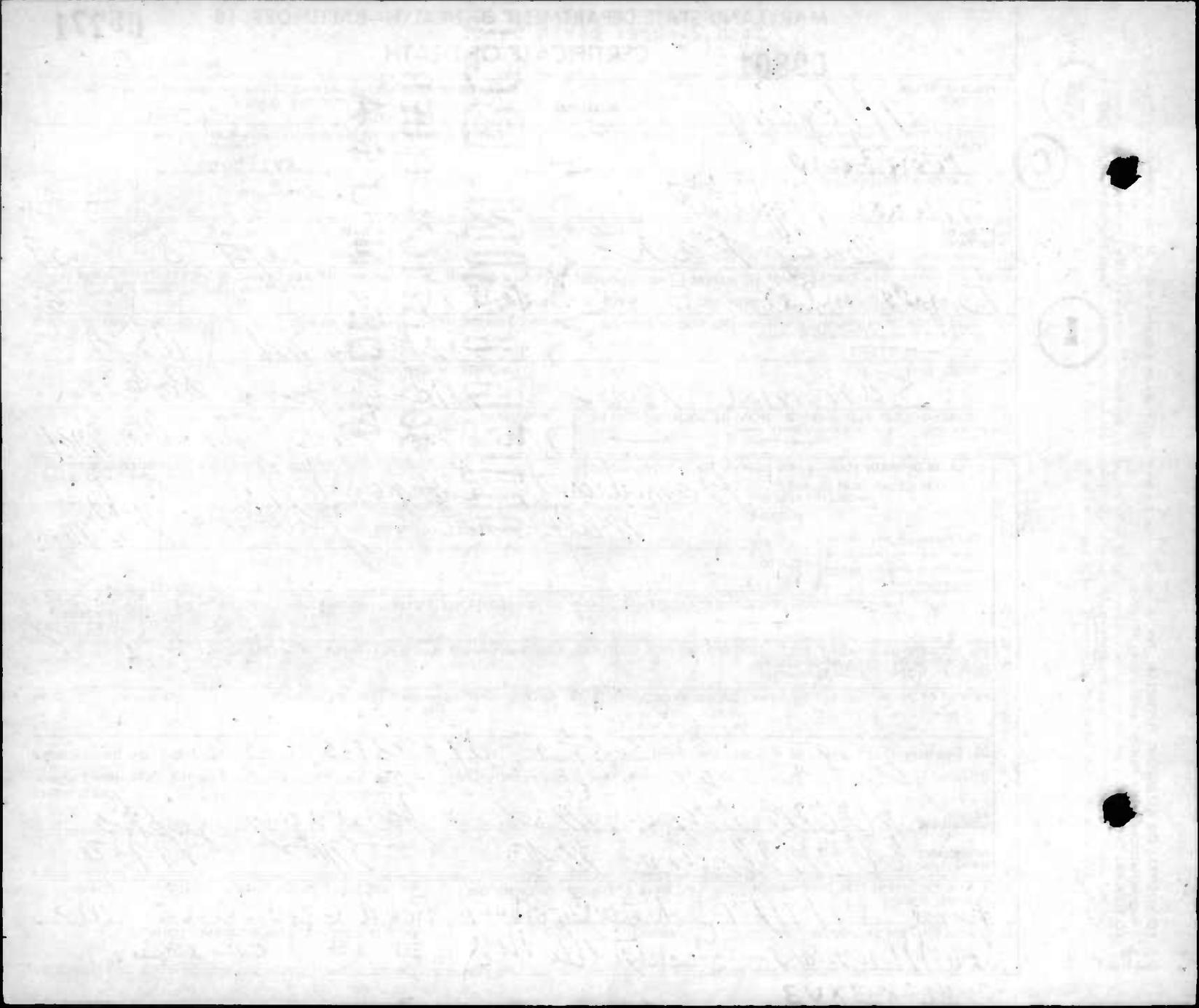
09801

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Allegany</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frostburg</i>		c. LENGTH OF STAY IN lb <i>17X-1</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address or institution) <i>Mineis Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Baby Parr</i>		First	Middle
4. DATE OF DEATH <i>Sept 5 1959</i>		Month	Day
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Sept 5 1939</i>		9. AGE (In years lost birthday) yrs. <i>11</i>	10. IF UNDER 1 YEAR Months <i>1</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>—</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (State or foreign country) <i>Frostburg Md</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Sammie Parr</i>	
14. MOTHER'S MAIDEN NAME <i>Mary Jane Rolsen</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>	
16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Mary Jane Parr</i>	Address <i>Avilton Md</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>756.2</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Prematurity - Congenital Malformation of abdomen</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>1 hr 6 min</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>—</i>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>			
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <i>Frostburg</i>
21. I certify that I attended the deceased from <i>Sept 5 1959</i> to <i>Sept 5 1959</i> , that I last saw the deceased alive on <i>Sept 5 1959</i> , and that death occurred at <i>Frostburg Md</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>WOMC</i>		ADDRESS (Street, city or town, state) <i>Frostburg</i>	
PHYSICIAN'S NAME (Type) <i>WOMC Lane Md</i>		DATE SIGNED <i>Sept 5 1959</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9/7/59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>NEW GERMANY</i>
22d. LOCATION (City, town, or county) <i>Rural Grantsville Md</i>		(State) <i>Mo</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ben Newman - Grantsville Md</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 9 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur & Thorne</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09773

09785

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 6 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
3. NAME OF DECEASED (Type or print) SUSAN		4. DATE OF DEATH PRYOR SEPTEMBER 1959	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 24	
9. AGE (In years lost birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS BRIDENTHAWAL		14. MOTHER'S MAIDEN NAME HESTER ANN PRICE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None	
17. INFORMANT Memorial Hospital, Cumberland, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan , 1959, to Aug , 1959, that I last saw the deceased alive on Aug 3, 1959 , and that death occurred at 8:30 AM from the causes and on the date stated above. ACTUAL SIGNATURE Arthur Himmelwright PHYSICIAN'S NAME (Type) G. OVERTON HIMMELWRIGHT		ADDRESS (Street, city or town, state) 1336 1/2 Ave, Cumberland, Md. DATE SIGNED 9/1/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/3/59	
22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. - Cumberland, Md.		24a. REC'D BY REGISTRAR SEP 8 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur & Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

03774

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09817

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
Allegany		MARYLAND Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maryland Route 55		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RD 2, Frostburg	
3. NAME OF DECEASED (Type or print)		First	Middle
Frederick		J.	Rankin
4. DATE OF DEATH	Month	Day	Year
September 17th, 1959			
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Sept. 16th, 1927
9. AGE (in years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
32 yrs.	Bartender	Maryland	USA
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
James Rankin	Mabel Gordon		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO.	17. INFORMANT	Address Box 183
W.W. 2	212-24-0219	Mrs. Mabel Rankin, RFD 2, Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fractured Skull-Frac. left leg</i> INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i>			
823X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Lacerations face & Shock</i> —			
DUE TO <i>as</i> (c) — —			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>car to highway at high rate of speed and went end over end</i>			
20c. TIME OF INJURY Month, Day, Year Hour 6:15 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <i>St. Mt. 55</i> (County) <i>Near Vale Summit Alleg. Md.</i> (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>R. J. Williams</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <i>acting</i>	
EXAMINER'S NAME (Type) R. J. Williams		DATE SIGNED <i>9/17/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-20-59	22c. NAME OF CEMETERY OR CREMATORIAL Porter Cemetery
22d. LOCATION (City, town, or county) Eckhart, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst, Frostburg, Md.		ADDRESS	
24a. REC'D BY REGISTRAR DATE SEP 21 '59		24b. REGISTRAR'S SIGNATURE <i>Orlina & Kress</i>	

MISSOURI STATE DEPARTMENT OF REVENUE
VEHICLE REGISTRATION CERTIFICATE OF DEATH

NAME	ADDRESS	NAME	ADDRESS
JOHN D. SMITH	1234 FAIRFIELD DR.	JOHN D. SMITH	1234 FAIRFIELD DR.

JOHN D. SMITH	1234 FAIRFIELD DR.	JOHN D. SMITH	1234 FAIRFIELD DR.
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JOHN D. SMITH	1234 FAIRFIELD DR.	JOHN D. SMITH	1234 FAIRFIELD DR.
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JOHN D. SMITH	1234 FAIRFIELD DR.	JOHN D. SMITH	1234 FAIRFIELD DR.
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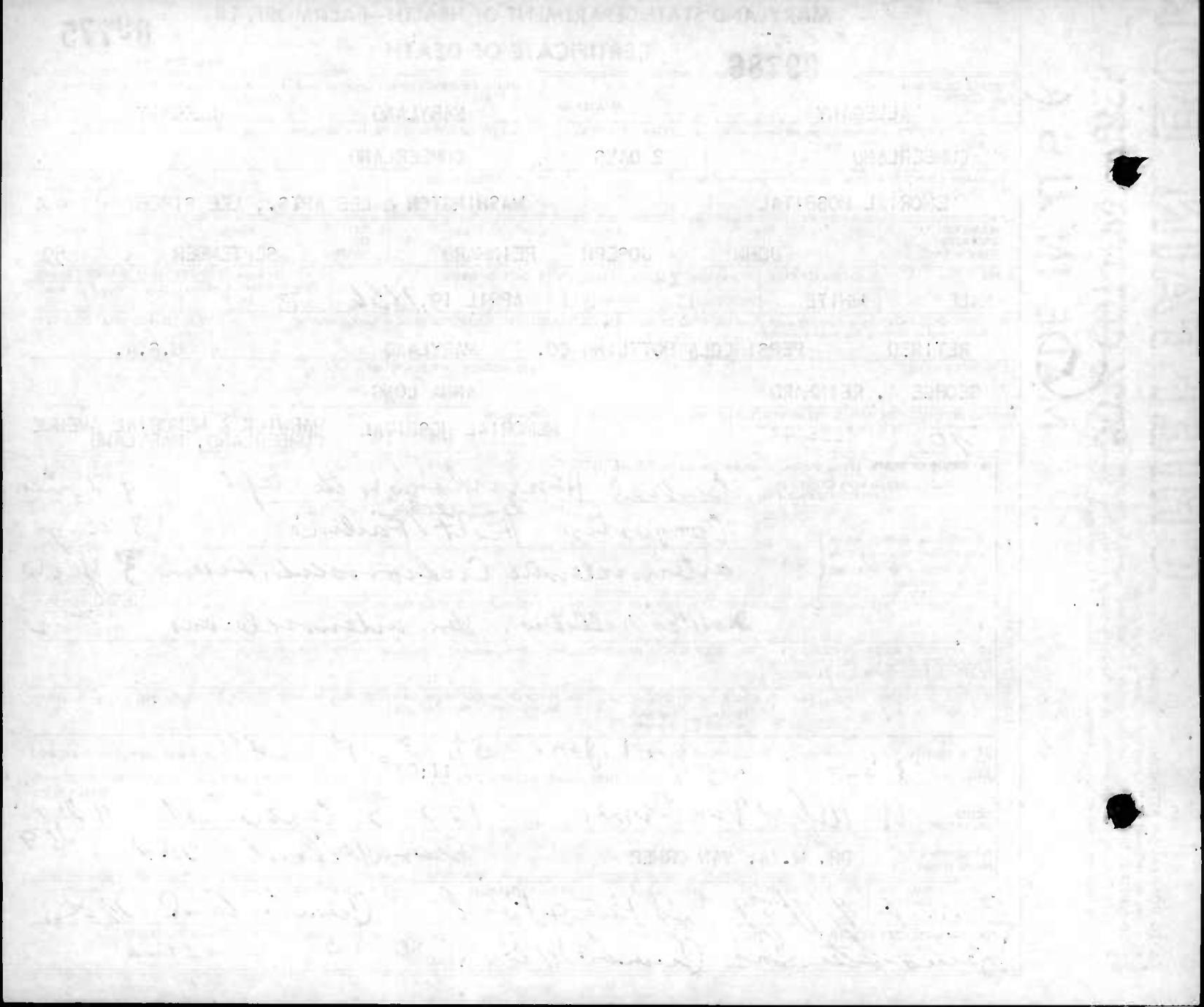
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09775

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN JOSEPH REINHARD		First JOHN	Middle JOSEPH
4. DATE OF DEATH SEPTEMBER 3 1959		Last REINHARD	Month Day Year
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 19, 1886
9. AGE (In years last birthday) 73	10. IF UNDER 1 YEAR yrs. 73	11. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY PEPSI COLA BOTTLING CO.	11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME GEORGE A. REINHARD		14. MOTHER'S MAIDEN NAME ANNA LONG	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) NO		16. SOCIAL SECURITY NO. 100-10-1000	INFORMANT MEMORIAL HOSPITAL
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) 422.1		INTERVAL BETWEEN ONSET AND DEATH 9 hours	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Cerebral Hemorrhage with left temporal lobe contusion Congestive Heart Failure arteriosclerotic Cardiovascular Disease	
DUE TO (b)		3 days	
DUE TO (c)		3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus, atherosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1 Jan. , 1957, to 3 Sept. , 1959, that I last saw the deceased alive on 3 Sept. , 1959, and that death occurred at 11:07 p.m. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 122 S. Centre St., Cumberland, Md.	
ACTUAL SIGNATURE W. Alfred Van Ormer		DATE SIGNED 4 Sept. 1959	
PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/7/59	22c. NAME OF CEMETERY OR CREMATORIAL St. Peter & Paul
22d. LOCATION (City, town, or county) Cumberland, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. Cumb. Md.		24a. REC'D BY REGISTRAR DATE SEP 9 '59	24b. REGISTRAR'S SIGNATURE Orion & Trahan



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 TSM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 09787

CERTIFICATE OF DEATH

Reg. Dist. No.

09777

1. PLACE OF DEATH o. COUNTY Allegany			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 5 days		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dansville													
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital			d. STREET ADDRESS Rural			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Leonard		First Wm		Middle Robertson		4. DATE OF DEATH Sept. 18 1959											
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/13/14		9. AGE (In years last birthday) 45 yrs.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.								
13. FATHER'S NAME Harrison Robertson						14. MOTHER'S MAIDEN NAME Laura Gracie											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. WW 112			INFORMANT Pt's chart.			Address								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Cerebral sclerosis Generalized arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 5 days											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)								
21. I certify that I attended the deceased from May 14, 1959 , to Sept. 18, 1959 that I last saw the deceased alive and May 14, 1959 , and that death occurred at M , from the causes and on the date stated above.						ADDRESS (Street, city or town, state)			DATE SIGNED								
ACTUAL SIGNATURE B. M. Schneider M.D.			22. BURIAL, CREMATION, REMOVAL (Specify) Burial						22b. DATE THEREOF Sept. 20, 1959			22c. NAME OF CEMETERY OR CREMATORIUM Waxler			22d. LOCATION (City, town, or county) (State) Danville, Md		
23. FUNERAL DIRECTOR'S SIGNATURE Roger J. Kreyer S. Clark						ADDRESS Roger J. Kreyer S. Clark			24a. REC'D BY REGISTRAR DATE SEP 23 '59			24b. REGISTRAR'S SIGNATURE Arthur J. Kreyer					

X1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09778

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maryland Route 55		c. LENGTH OF STAY IN lb 22 Fros tburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 118 McCulloh St.	
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Robert		First D.	Middle Seifarth
4. DATE OF DEATH September 17th, 1959	Month September	Doy 17	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 30th, 1919
9. AGE (in years last birthday) 40 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
13. FATHER'S NAME Andrew Seifarth	14. MOTHER'S MAIDEN NAME Ruth Walsh		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 823X	16. SOCIAL SECURITY NO. 215-14-6373	17. INFORMANT Mrs. Edith C. Seifarth	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture both legs, side of chest & shock
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Auto hit culvert at high rate speed and endorsement	DUE TO (b) 823X	DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto hit culvert at high rate speed and endorsement		
20c. TIME OF INJURY Month, Day, Year Hour 6:15 a.m. 9/17/59	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 8:15 a.m. 9/17/59	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Year Vale Cemetery - all	20f. (City or town) (County) (State) Frostburg, Allegany - Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R. J. Williams		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> II DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 9/17/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-20-59	22c. NAME OF CEMETERY OR CREMATORIUM F'bg. Memorial Park	22d. LOCATION (City, town, or county) (State) Frostburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst, Frostburg, Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE SEP 21 '59	24b. REGISTRAR'S SIGNATURE Carlton E. Koenig

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designee, or agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

WISCONSIN STATE GOVERNMENT OF HEALTH - INSURANCE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE BOU
LAW 1974

NAME OF DECEASED: John Doe

ADDRESS: 123 Main Street, Anytown, WI 54411

AGE: 55

SEX: Male

WEIGHT: 180 lbs

HEIGHT: 5'10"

HAIR: Dark brown

EYES: Brown

RELIGION: Methodist

EDUCATION: High School Graduate

EMPLOYMENT: Retired

DEATH DATE: May 1, 2023

DEATH TIME: 10:00 AM

DEATH PLACE: At home

CAUSE OF DEATH: Cardiac Arrest

DEATH CERTIFIED BY: Dr. John Doe, MD

DEATH CERTIFIED BY: John Doe, RN

DEATH CERTIFIED BY: John Doe, LPN

DEATH CERTIFIED BY: John Doe, EMT

DEATH CERTIFIED BY: John Doe, Paramedic

DEATH CERTIFIED BY: John Doe, Doctor of Osteopathy

DEATH CERTIFIED BY: John Doe, Chiropractor

DEATH CERTIFIED BY: John Doe, Acupuncturist

DEATH CERTIFIED BY: John Doe, Homeopath

DEATH CERTIFIED BY: John Doe, Naturopath

DEATH CERTIFIED BY: John Doe, Traditional Chinese Medicine Practitioner

DEATH CERTIFIED BY: John Doe, Ayurvedic Practitioner

DEATH CERTIFIED BY: John Doe, Holistic Health Practitioner

DEATH CERTIFIED BY: John Doe, Integrative Medicine Practitioner

DEATH CERTIFIED BY: John Doe, Functional Medicine Practitioner

DEATH CERTIFIED BY: John Doe, Anti-Aging Medicine Practitioner

DEATH CERTIFIED BY: John Doe, Regenerative Medicine Practitioner

DEATH CERTIFIED BY: John Doe, Sports Medicine Practitioner

DEATH CERTIFIED BY: John Doe, Pain Management Practitioner

DEATH CERTIFIED BY: John Doe, Endocrinology Practitioner

DEATH CERTIFIED BY: John Doe, Gastroenterology Practitioner

DEATH CERTIFIED BY: John Doe, Cardiology Practitioner

DEATH CERTIFIED BY: John Doe, Pulmonology Practitioner

DEATH CERTIFIED BY: John Doe, Nephrology Practitioner

DEATH CERTIFIED BY: John Doe, Hematology Practitioner

DEATH CERTIFIED BY: John Doe, Oncology Practitioner

DEATH CERTIFIED BY: John Doe, Endocrinology Practitioner

DEATH CERTIFIED BY: John Doe, Gastroenterology Practitioner

DEATH CERTIFIED BY: John Doe, Cardiology Practitioner

DEATH CERTIFIED BY: John Doe, Pulmonology Practitioner

DEATH CERTIFIED BY: John Doe, Nephrology Practitioner

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09779

09789

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 2 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 35 South Street		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Florence	First Rebecca	Middle Shryock	4. DATE OF DEATH September 28
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 25 1874
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Town Creek, Maryland
13. FATHER'S NAME Upton Athey		14. MOTHER'S MAIDEN NAME Sarah Athey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Mrs. Clara Buser,
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0		INTERVAL BETWEEN ONSET AND DEATH 6 mo	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Arterosclerosis		(c) 15 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 1956 to Sept 28, 1958 that I last saw the deceased alive on Sept. 20, 1958 , and that death occurred at 3:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Clay E. Durrett		ADDRESS (Street, city or town, state) 236 Virginia Ave. Cumberland, Maryland	
PHYSICIAN'S NAME (Type) Clay E. Durrett M.D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 30, 1959	22c. NAME OF CEMETERY OR CREMATORIUM Shryock Cemetery	22d. LOCATION (City, town, or county) Town Creek, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR OCT 2 '59	24b. REGISTRAR'S SIGNATURE John J. Hafer

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09788

CERTIFICATE OF DEATH

Reg. Dist. No.

09780

1. PLACE OF DEATH a. COUNTY CUMBERLAND ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 10 HOURS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND		d. STREET ADDRESS 1224 S. LEE ST.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) FLORA ESTELLA		First	Middle	Last	4. DATE OF DEATH SMITH	Month SEPT.	Day 19	Year 1959	
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 28, 1899	9. AGE (In years (last birthday) 60 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME THOMAS COOK (DECEASED)		14. MOTHER'S MAIDEN NAME ELMIRE <i>Naylor</i> (DECEASED)							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Y		16. SOCIAL SECURITY NO. None		INFORMANT		Address			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 175.0 DUE TO <i>Concussion of the brain</i>						INTERVAL BETWEEN ONSET AND DEATH 8 months			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) CUMBERLAND		(County) MARYLAND	(State) MARYLAND
21. I certify that I attended the deceased from 3-4- , 19 59 , to 9-10- , 19 59 , that I last saw the deceased alive on 9-10- , 19 59 , and that death occurred at 3:50 P.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>L. Brings</i>		M.D.		ADDRESS (Street, city or town, state) 57 GREENE ST., CUMBERLAND, MARYLAND					
PHYSICIAN'S NAME (Type) LEWIS BRINGS, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/21/59		22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cem.		22d. LOCATION (City, town, or county) Cumb.		(State) MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lewis Stein Inc.</i>		ADDRESS Cumb. Md.		24a. REC'D BY REGISTRAR DATE SEP 23 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

00140

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28780

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09781

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Mt. Savage

c. LENGTH OF STAY IN 1b

45 Yrs.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

3. NAME OF
DECEASED
(Type or print)First
Frank

Middle

Last

4. DATE
OF
DEATH

September 1st, 1959

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

May 12th, 1889

9. AGE (In years
last birthday)

70 yrs.

10. IF UNDER 1 YEAR

11. IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Ret.-oiler Spin. Dept. Celanese Corp.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Catherine Snyder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17-10-7385

INFORMANT

Address

Mrs. Margaret B. Snyder, Mt. Savage, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Carcinoma Pancreas

INTERVAL BETWEEN
ONSET AND DEATH

6 months

157X

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19 p. m.20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 5/4, 1957, to 9/1, 1959, that I last saw the deceased alive on 8/30, 1959, and that death occurred at 220 M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATUREPHYSICIAN'S
NAME (Type) Hilda Jane Walters

M.D.

Frostburg, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 9-4-59

22b. DATE THEREOF
22c. NAME OF CEMETERY OR CREMATORIUM
Methodist Cemetery

22d. LOCATION (City, town, or county) Mt. Savage, Md. (State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Joseph R. Durst, Frostburg, Md.

24a. REC'D BY REGISTRAR *Arthur H. King* 9-4-59
DATE24b. REGISTRAR'S SIGNATURE *Arthur H. King*

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FOR STATE
HEALTH DEPT.
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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09782

Reg. Dist. No.

09790

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 45 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Memorial Hospital		e. STREET ADDRESS 1410 Broadway	
3. NAME OF DECEASED (Type or print) Orlando		First Ray	Middle Spangler
4. DATE OF DEATH Sept. 8 1959		Last Spangler	Month Sept.
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. B. DATE OF BIRTH March 18, 1886		9. AGE (in years last birthday) 73 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor-retired		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Huntington, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jeremiah Spangler		14. MOTHER'S MAIDEN NAME Sarah	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 705-09-7929	
17. INFORMANT Mrs. Mae Spangler, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		INTERVAL BETWEEN ONSET AND DEATH deceased	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		<i>Coronary Thrombosis</i>	
DUE TO (c)		<i>Coronary Artery Disease</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Hour 8:30 a.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		DATE SIGNED 9/10/59	
ACTUAL SIGNATURE <i>Richard J. Williams</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Richard J. Williams, MD		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 9-11-1959		22c. NAME OF CEMETERY OR CREMATORIUM Terra Alta Cemetery	
22d. LOCATION (City, town, or county) Terra Alta, W. Va.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		24a. REC'D BY REGISTRAR DATE SEP 14 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09783

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

09791		1		X		M		060		1		0		1		/		1	
1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND		d. STREET ADDRESS 1 AUBURN AVENUE													
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) CHARLES		First	Middle W.	Last TIPTON	4. DATE OF DEATH SEPTEMBER 11 1959	Month SEPTEMBER	Day 11	Year 1959											
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 1, 1910		9. AGE (In years lost birthday) 49 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None Spinner		10b. KIND OF BUSINESS OR INDUSTRY Textile, Yarn		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA Blaine		12. CITIZEN OF WHAT COUNTRY? U.S.A.													
13. FATHER'S NAME CHARLES TIPTON		14. MOTHER'S MAIDEN NAME BERTHA BARNHART																	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-07-5488		INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND		WARWICK & ^{Adams} MEMORIAL AVENUE													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]																			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> 1 day																			
420.0 DUE TO																			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Arteriosclerotic heart disease</i> 6 yrs																			
DUE TO (c)																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Old myocardial infarction - 1953</i>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21. I certify that I attended the deceased from _____, 1953, to Sept 11, 1959, that I last saw the deceased alive on Sept 11, 1959, and that death occurred at 6:15 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Al Weisman</i>		M.D. 59 GREENE ST		ADDRESS (Street, city or town, state) CUMBERLAND, MD		DATE SIGNED 9/12/59													
PHYSICIAN'S NAME (Type) DR. WEISMAN																			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-14-59		22c. NAME OF CEMETERY OR CREMATORIUM Sunset Memorial Park		22d. LOCATION (City, town, or county) Cumberland, Md. (State)													
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE SEP 17 '59		24b. REGISTRAR'S SIGNATURE <i>John J. Kline</i>													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

u9784

09792

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. Va.		b. COUNTY Mineral		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wiley Ford		d. STREET ADDRESS 85 x-3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Bruce		First H.	Middle Ward	Last	4. DATE OF DEATH Sept. 27 1959	Month	Day	Year
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 4/5/05	9. AGE (In years last 54 yrs.)	IF UNDER 1 YEAR Months 5	IF UNDER 24 HRS. Days 4	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tire Repairman		10b. KIND OF BUSINESS OR INDUSTRY Tire Manuf. Co.		11. BIRTHPLACE (State or foreign country) W. Va.-Short Gap		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Mrs. Bruce Ward, Wiley Ford, W. Va.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 493 X		pneumonia						INTERVAL BETWEEN ONSET AND DEATH 7 days
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO								
(c) DUE TO								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) pneumonia, for bronchietasis 1954								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 9-23- 1954 , to 9-27- 1954 , that I last saw the deceased alive on 9-26 1954 , and that death occurred at 11:45 PM , from the causes and on the date stated above.								
ACTUAL SIGNATURE L Brings		ADDRESS (Street, city or town, state) 57 Green St., Cumberland, Md.						
PHYSICIAN'S NAME (Type) Lewis Brings, M.D.		DATE SIGNED						
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 9-30-1959		22c. NAME OF CEMETERY OR CREMATORIUM Fort Ashby Cemetery		22d. LOCATION (City, town, or county) Fort Ashby, W. Va.		
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE OCT 52 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kline		

10450 TO STADRIFF2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09785

09793

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 2 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 721 Lafayette Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HOWARD		First BROWSON	Middle WELLER
4. DATE OF DEATH September 14 1959		Month September	Day 14
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Sept. 26, 1876		9. AGE (In years lost birthday) 82 yrs.	10. IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Engineer		10b. KIND OF BUSINESS OR INDUSTRY B & O Railroad	11. BIRTHPLACE (State or foreign country) Fairview County, Penn.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Hezekiah Weller	
14. MOTHER'S MAIDEN NAME Mary Ellen Allison		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. 420.1		17. INFORMANT Howard Weller	Address Montreal Avenue
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH acute	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Myocarditis & Decompensation		3 years	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 1958 to Sept 14 1959 , that I last saw the deceased alive on Sept. 12 1959 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. 236 Virginia Avenue, Cumberland, Md.	
ACTUAL SIGNATURE Clay E. Durrett		DATE SIGNED 9/17/59	
PHYSICIAN'S NAME (Type) Clay E. Durrett, M.D.		23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 18, 1959	22c. NAME OF CEMETERY OR CREMATORIAL Greenmount Cemetery
22d. LOCATION (City, town, or county) Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE SEP 18 '59	
24b. REGISTRAR'S SIGNATURE Arthur & Kraus			

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09786

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for our files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transport permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 6 Yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 89½ Braddock Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John		First Robert	Middle Whetstone
4. DATE OF DEATH Month September Day 24th , Year 1959		5. SEX Male	6. COLOR OR RACE White
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Dec. 12th, 1952	9. AGE (In years last birthday) 6 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Boy		10b. KIND OF BUSINESS OR INDUSTRY School	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME James J. Whetstone		14. MOTHER'S MAIDEN NAME Betty James	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT James J. Whetstone, Frostburg, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 919.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Deceased & Brother Playing with Rifle at their Home		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased & Brother Playing with Rifle at their Home	
20c. TIME OF INJURY Month, Day, Year Sept 24 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) Home
20f. (City or town) Near Frostburg Allegany Md		(County) Near Frostburg Allegany Md	
(State) Near Frostburg Allegany Md			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W. O. McLane		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) W. O. McLane,		DATE SIGNED Sept 25 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-26-59	22c. NAME OF CEMETERY OR CREMATORIAL F'bg. Memorial Park
22d. LOCATION (City, town, or county) Frostburg, Md.		(State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst, Frostburg, Md.		24a. REC'D BY REGISTRAR SEP 28 '59	24b. REGISTRAR'S SIGNATURE Arthur K. Krasus
ADDRESS		DATE	

STATE OF
INDIA

MANUFACTURE OF
EXTRACTION OF OILS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
 may be retained by the hospital or attending physician and completely filled in by the general director.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

19787

09794

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 18 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LONACONING, MARYLAND	
d. STREET ADDRESS CHARLESTON STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First HOWARD	Middle THOMAS	Last WILSON
4. DATE OF DEATH	Month SEPTEMBER	Day 9	Year 1959
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19th NOVEMBER 1896
9. AGE (In years last birthday) 62 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME William WILSON		
14. MOTHER'S MAIDEN NAME REBECCA METZ	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		
16. SOCIAL SECURITY NO.	INFORMANT	17. WARWICK & MEMORIAL AVENUE MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 141.9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Squamous cell carcinoma of tongue. E. widoed metastasized Nov '57 (c) Since DUE TO DUE TO DUE TO			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8. 22. 1959 to 9. 9. 1959 that I last saw the deceased alive on 9. 9. 1959 , and that death occurred at 4:40 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W. F. Williams, M.D.</i>	ADDRESS (Street, city or town, state) Lonaconing, MD.		
PHYSICIAN'S NAME (Type) DR. W.F. WILLIAMS	DATE SIGNED Sept 10 1959		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/12/1959	22c. NAME OF CEMETERY OR CREMATORIAL Oak Hill Cemetery	22d. LOCATION (City, town, or county) Lonaconing, MD.
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN	ADDRESS LONACONING, MD.	24a. REC'D BY REGISTRAR SEP 14 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur & Frank</i>

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09788

Reg. Dist. No.

09795

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 02 Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) B&O Railroad Yards, Cumberland Md.		d. STREET ADDRESS Box 80 Potomac Park	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Vermont		First Gilbert	Middle Zollner
4. DATE OF DEATH Sept. 3 1959		Last	Month
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH April 7, 1923		9. AGE (In years (on birthday) 36 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carman Helper		10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (State or foreign country) Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Oswald G. Zollner		14. MOTHER'S MAIDEN NAME Clara E. Kaylor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. War II	
17. INFORMANT Grant E. Zollner, Cumberland, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) 976x DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. Self inflicted DUE TO (b) Mentally ill - DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Planned	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Gun shot wound head self inflicted	
20c. TIME OF INJURY Month, Day, Year Hour 6 a. m. 9/3/59 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Box 80 Potomac Park, 2nd, Cumberland, Allegany
20f. (City or town) Cumberland		(County) Allegany (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B. J. Williams		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> (acting) 9/3/59 DATE SIGNED	
EXAMINER'S NAME (Type) Dr. Richard J. Williams			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-5-1959	22c. NAME OF CEMETERY OR CREMATORIAL Davis Memorial Cemetery
22d. LOCATION (City, town, or county) Cumberland, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		ADDRESS James F. Scarpelli, Cumberland, Md.	24a. REC'D BY REGISTRAR DATE SEP 8 '59
		24b. REGISTRAR'S SIGNATURE Arthur & Krause	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for further files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 7 hours after death.

